from population control to reproductive health

malthusian arithmetic

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For Githa, Rishab, and Nishad

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AIDWA	All India Democratic Women's Association
ANM	Auxiliary Nurse Midwife
ARI	Acute Respiratory Infection
BPL	Below Poverty Line
CDR	Crude Death Rate
CEDAW	UN Convention on the Elimination of All Forms of Discrimination against Women
CPR	Couple Protection Rate
CRPS	Centre for Research on Population and Security
CSR	Child Sex Ratio
CWDS	Centre for Women's Development Studies
CWPE	Committee for Women, Population, and Environment
FPAI	Family Planning Association of India
GDP	Gross Domestic Product
GM	Genetically Modified
GNP	Gross National Product
ICMR	Indian Council of Medical Research
ICPD	International Conference on Population and Development
ICSSR	Indian Council of Social Science Research
IFA	Iron, Folic Acid, Vitamin A Tablets
IFFH	International Federation of Family Health
IMR	Infant Mortality Rate
IPPF	International Planned Parenthood Foundation
IUCD	Intrauterine Contraceptive Device
IWHC	International Women's Health Coalition
KAP	Knowledge Attitude Practice
MMR	Maternal Mortality Rate

MNP	Minimum Needs Programme
MTP	Medical Termination of Pregnancy
NFHS	National Family Health Survey
NIFP	National Institute of Family Planning
NIHAE	National Institute for Health Administration and Education
NPC	National Planning Committee
NPP	Nation Population Policy
NRI	Non-resident Indian
NSS	National Sample Survey
NTP	National Tuberculosis Programme
PDS	Public Distribution System
PHC	Primary Health Care
PRIs	Panchayati Raj Institutions
RTIs	Reproductive Tract Infections
SAP	Structural Adjustment Programme
SRB	Sex Ratio at Birth
STDs	Sexually Transmitted Diseases
TFR	Total Fertility Rate
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
WEDO	Women's Environmental and Development Organisation
WGNRR	Women's Global Network for Reproductive Rights
WHO	World Health Organisation

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I have lost so many babies .... I cried and cried each time. I wanted them, I wanted them so much, I wanted them to live. But how much pain does a tear hold? I have to keep working and I still don't manage to feed our stomachs .... I too want my children to wear good clothes, to read, go to college, get good jobs, but what is the point? I am told I cause all our problems and was told to get operated. I refused. What else could I do? Put on jasmines in my hair when we don't have food? What would you have done in my place?

—A landless Adi Karnataka woman in a village
in Mandya district, Karnataka.

I have incurred huge and terrible debts in putting together this work. All the mountains of intellectual and other debts producing this mouse of a work! But how do I thank everyone involved in this intellectual journey?

The data that I gathered out of 584 households in three villages of Mandya district in Karnataka during my Ph.D field study is largely not here. Nevertheless, that is what informs this work, guides it, and provides something of an agonising whetstone. I was frequently asked on the field, what would you have done in my place? This is something that has stayed with me, cautioned me, and sometimes given me courage to express views no one would like to hear. What they shared with me, unspeakably rich, of pain, cruelty, hopes and joys of their lives, of their children, is here in this work, haunting it, enfolding it, indeed gilding it. How can I ever thank them?

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INTRODUCTION

I have been interviewing medical graduates for a post-graduate programme in public health over the last 17 years. During the course of the admission interview, one question I frequently ask is: what are the major public health problems in India? The answer, in this order, is almost invariably, population explosion, AIDS, and cancer. What is perhaps not astonishing is that issues like high infant and child mortality rates, a high maternal mortality rate, huge and increasing load of tuberculosis, malaria, and, above all, hunger, which links all of them, do not apparently appear on the public health landscape in India anymore.

How has this come about? Is this merely the influence of the teaching in medical colleges? Is it the 'common sense' that binds together otherwise disparate people in the middle classes on the issue of population? Is it the role of the media? In other words, how is it that the population control establishment has been so successful in selling its message? This is something that indeed needs to be researched, but what I attempt to do here is merely derived from my attempts to shake my student's certitude, to understand a question critically, indeed, to pose the question differently, to arrive at yet another set of questions and issues; that is to say, the banal but forgotten academic understanding that critiquing is useful, legitimate, and indeed necessary.

As a doctor, I was trained to protect lives, cure diseases, hasten recovery, and so on; only rarely was prevention part of the rubric of what we were taught. But my training as a doctor did not teach me to try to understand a problem historically. It seemed evident—oh woeful ignorance!—that history and politics had nothing to do with health problems. Thus we were never taught that colonialism was accompanied by the depopulation of several peoples, indeed continents. Nor that, as Sen shows us so brilliantly, the Bengal famine was essentially a matter of politics, not population growth and hence a result of food availability deficit. It was adumbrated that population growth caused the problems of ill-health and poverty in the country.

The solution was family planning and educating the people about its virtues, convincing them that whatever technology was currently fashionable was the answer not only to their family's myriad problems of survival and ill-health, but also the nation's.

My effort here is modest, terribly, terribly modest. I have surveyed, often from a height, a great many arguments, many areas of research that have been dealt with more effectively by others. I have tried to condense them, put them across sharply—some may argue too sharply—and make them accessible. I have deliberately avoided, as far as possible, tables and graphs. Although not abjuring numbers, what I have tried to do is to engage with ideas, exploring the contexts and the contradictions.

The issue of population is so defeatingly complex, so embroiled and entangled in a host of other issues—often seemingly unrelated—that no obviously sane person can deal with all of them. I have, therefore, guiltily left out some themes. I am equally aware that I have seldom used the words gender, patriarchy, class, or imperialism! These are, of course, central to understanding the issue. But in my hesitant defence, I would argue that my primary purpose has been to locate and critique the family-planning programme in India, its assumptions, unstated biases, and implications. This is just one small text, not exegesis.

Since everyone who matters agrees that population is the biggest social problem in the country, how is it that the family-planning programme, one of the largest public health initiatives in the world, has consistently fallen short of its objectives? Even if one were to agree that the issue is bringing down growth rates for the good of the nation, are we approaching the problem as we ought to—ensuring health and security to people's lives? If not, why not? My argument is that we have posed the question incorrectly, and have thus come up with answers that have been seriously misleading, putting the metaphorical cart before the horse, in a country where the vast majority of people have, of course, neither cart nor horse. What has occurred, therefore, is that issues of health have not received the central attention they ought to have. Not only has the health of the population not been of central concern, but also the vision of health has been severely diminished by a sort of technological hubris. Health has become divorced from levels of living, of conditions of work, of access to food, of striving for equality and justice; it has come to be equated with doctors, hospitals, and technical interventions. How

and why this has come about, although extraordinarily salient, is, however, not dealt with here, except tangentially.

The result is that the entire public health infrastructure, neglected, starved of funds, almost dysfunctional, has been suborned for family planning. This has two consequences: it drives more and more people into the exploitative arms of the huge, growing, and unregulated private sector; it also drives people, especially the poor, who seek, for example, maternal and child health care, away from the public health system. Ironically, today these very features of the public health system—created by public policy—are used, under the aegis of the World Bank, as reasons to further privatise health care. This is a typical case of a public health prescription that was meant to go awry.

The entire primary health care (PHC) system, then, has become besmirched with population control concerns. I explore in the first chapter, the evolution and growth of the family-planning programme, the shifts in strategy and emphasis, some of the factors that influenced these shifts, to arrive at where we are today. A number of other works have dealt with the nature and pattern of funding, of discourse—the whole range of international efforts moulding the programme in all Third World countries. I have, therefore, refrained from dilating on this issue, while, of course, drawing attention to it. Other works have also dealt with the range of other reproductive technologies—injectables, implants, anti-fertility vaccines—and the trajectories of their use in India. Again, the reader will be referred to these works.

The second chapter examines the ideological underpinnings of population control. Here is a coming together of diverse histories, of facts and prejudices, of half-truths masquerading as explanations—thus the issue of method. There is such an embarrassing wealth of literature in the area that I have perforce had to be extremely selective, if sometimes brutal. I attempt to locate Malthusianism and neo-Malthusianism in their contexts, tracing some of the politics that moulded them. I am obviously guilty of a number of omissions here, in particular the literature that fundamentally questions Malthusian and neo-Malthusian literature empirically and methodologically. It would require another book to do justice to this rich literature that I have alluded to. I have omitted in this narrative how the developments in the science of genetics discredited the fundamental certitudes of eugenics. This is because eugenics was discredited not so much by science as by contemporary politics. The ideas of race, of racial improvement, indeed of racial purity, were so tarnished by Nazi

Germany that its acolytes went underground—alas only for a period. For, these ideas have not only resurfaced in contemporary politics in India, but throughout the world. This chapter is thus important for we live in shamelessly ahistorical times.

What is the data on poverty and family size? Who indeed are the poor? Is there data that consistently reveals, for instance, that landless labourers, who form about 40 per cent of out agrarian population and are largely unable to meet their calorie requirements, have a larger family size than, say the rich peasants? Whether or not they are responsible for the poverty of the country is a separate question, not necessarily linked. They are nevertheless yoked together in the common argument that the poor breed too much and are responsible for poverty. How does income, occupation, landholding, and caste together—in short, class—relate to family size? The truth of the matter is that we simply have no such data. Why we do not have such critical data is yet another issue that needs exploring, but what is equally moot is that if public health is about prevention, we need to know why some groups have more births than others. Could this have something to do with high death rates? What is the distribution of births and deaths among different segments of the population? When I looked for data on births, deaths, and family size by socio-economic groups, I found very little that was worthwhile, reliable, and consistent. The truth of the matter, of course, is that we have not looked for better data, since we have not imagined it. It is enough that we think health and population have merely geographical or spatial characteristics, never social. For as recent works on inequalities in health attest, population averages, while, of course, useful in a rough and ready manner, are also extremely limited and indeed may be unreliable guides to what is occurring in different groups in a population. Making what is referred to as the 'health divide' visible implies that data on health by social groupings should be as natural as the current universal practice of describing the health status by age groups or by sex. It has been remarked that Malthusian discourse was peculiarly sexless. While the deafening silence on gender was inexcusable then, almost as indefensible is the current discourse on gender, much of which silences class.

In the past, when a family-planning programme utilising a particular approach ran aground—as it inevitably did—the way out of the impasse was adopting a new approach built around a new technology. Thus with the failure of the clinic approach began the extension education

approach. But before this could really get off the ground, the intrauterine contraceptive device (IUCD) was hailed as the magic bullet to defuse the population bomb—to use mixed militarist metaphors! The IUCD approach having failed, it was vasectomies, and that being politically costly, attention turned to female sterilisation. Yet even this seemed to lead down a blind alley.

It was at this point, in the 1990s there occurred what has been described as a 'paradigm shift' in the population debate, coming to a head at the International Conference on Population and Development (ICPD) in Cairo in 1994. What exactly did this paradigm shift imply? Did the concept of reproductive rights get privilege over rights to health? I trace in the fourth chapter some of the many factors that came together in a strange marriage of rights and international debts. Multinational feminisms—as opposed to women's movements with an internationalist perspective—were deeply involved in forging this consensus with international donors and national governments. Now that the neo-conservative Bush regime in the USA, allied with the Vatican and indeed some Islamic countries (strange are the bedfellows in politics!) threatens even the small step forward that this battle for reproductive rights represents, it is crucial that battle lines be drawn and we should, in a sense, man the barricades. It is nevertheless critical to remember that it is a small step, that reifying reproductive rights meant that we lost the vision and potentials that primary health care represented.

How has the paradigm shift translated into policies and programmes in India? Although India was a signatory to the ICPD, and prominent Indians played a role in shaping the Cairo consensus, the concept of reproductive rights seems to have very few takers in the country. How else does one explain the fact that a number of state population policies seem not have been aware of India's commitments at ICPD? While the National Population Policy (NPP) does frame a Reproductive and Child Health (RCH) Policy, this is done in isolation from health. Indeed both the health policy and NPP are drawn up in black boxes, with no reference to what the implications of macroeconomic changes have been to the health of people and the structures of health care. Were the commitments made at Cairo genuine? Or did they represent rhetorical obeisance to the dictates of funding agencies, in this case the World Bank, which too was one of the leading lights of reproductive rights? Chapter 5 discusses these issues and the evidence is mixed. While there is a genuine commitment to reproductive rights

in some quarters, there is nevertheless a strong hawkish tendency wishing to go back to explicit coercion.

I end with some questions, discussed in the concluding chapter. It seems quite incomprehensible, this successful appeal to an idea which has so little to back it. What explains the continuing sway of neo-Malthusian dogma? Is this related to the short historical memories of the middle classes who have forgotten their own family histories? It is true that neo-liberalism appeals to the ideas of nature red in tooth and claw, the ideas of distrust and competition—as opposed to trust and cooperation—in all of us. But why do calls to insecurities, to anxieties, to unreasonable fears seem to pay dividends? I am afraid I really have no answers.

What is truly frightening today in a deeply divided and indeed fragmenting world, are the calls for identity that 'think with blood', an atavistic harking back to ideas of racial purity defining a nation. A brave new eugenic world in the offing! This has been referred to as the dawn of global tribalisms. But as Hichens reminds us: 'We live in the pre-history of the human race, where no tribalism can be much better than another, and where humanism, so much derided and betrayed, needs an unsentimental and decisive statement' (Hitchens, 2000).

This work is also, however, a sentimental statement. I hope my granddaughters, reading this work, will wonder what all the fuss was about.

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I

THE INDIAN FAMILY-PLANNING PROGRAMME

Concerns about population growth in India began to be expressed late in the nineteenth century, ironically when there was little or no data to establish the fact of population growth. The 1891 Census Report, for example, invoked Malthus to contend that overpopulation was responsible for poverty in India (Banerji, 1985: 174). This was then repeated in subsequent censuses also when, in the India subcontinent, population growth actually dates back to the 1920s and makes its appearance only on comparison of the censuses of 1921 and 1931.

Efforts towards an official policy and programme were first made in the early decades of the twentieth century. Close to the dawn of Independence, the Indian National Congress established the National Planning Committee (NPC) in 1938, under the chairmanship of Jawaharlal Nehru, to outline the shape of India's tryst with destiny and to contour it. One of the sub-committees, chaired by Col. Sokhey, was devoted to the question of health policy. The Sub-Committee on Health also considered, quite naturally, the question of population and maternal and child health. At a time when no nation in the world sponsored a family-planning programme, Laksmibai Rajwade forcefully argued the case for the inclusion of 'birth control, provision of goods, instructions, demonstrations and consultations' in maternal and child health services. Birth control, she argued:

> ... is obviously a very important function in view of the fact that the high mortality among mothers and children is in part due to too frequent pregnancies involving a terrific strain on the nerves and on a vitality already abnormally low. Children are born not as a creative evolutionary response to the vital urge, but as brittle standardised products

> of a tired reproductive machinery automatically set in motion by the sexual act. The reproductive system has to be kept fresh and vitalised to respond creatively and must not therefore be subjected to that strain. That can only be done by controlling pregnancy by contraceptive methods. (NPC, 1948a: 133)

Calling for the creation of a 'comprehensive medical service financed wholly by the State, available to all persons' (ibid.: 158), Rajwade pointed out that 'to keep up the interplay of life and death about 20 mothers have to starve or poison themselves to death for every thousand of births; that out of the thousand born at such awful cost nearly 175 to 200 die before they are a year old; that on the scarred survivors of this stupendous ordeal is laid the responsibility of reproducing and building up their race in this land' (NPC, 1948b: 119).

The Sub-Committee also favoured birth control in the interests of the development of the nation, thus linking individual and family behaviour to national growth and indeed the teleology of progress and welfare. The nation state was conceived of as a body composed of physically and morally healthy citizens to which all must contribute (Zachariah, 2001: 3816–32). This could be achieved through reproductive prudence, harnessing bodies not just for the economy but for a sublime, and sublimating, nation state. Thus the Sub-Committee on Population, for example, which called for birth control on eugenic grounds and on the grounds of the health of women, called for 'self-control' along with birth control. It also recommended inter-caste and inter-faith marriages 'for eugenic and other social reasons' (NPC, 1948b: 208).

The NPC's Sub-Committee on Women's Role in Planned Economy resolved:

> The health programme of the state shall aim at the eradication of serious diseases, more especially such as are communicable or transmissible by marriage. The state should follow a eugenic programme to make the race physically and mentally healthy. This would discourage marriages of unfit persons and provide for the sterilization of persons suffering from transmissible diseases of a serious nature, such as insanity or epilepsy. (NPC, 1948c: 114)

The fact that ideas of birth control was accepted with such ease, testifies to the great influence, indeed the popularity of eugenic ideas among Indian élites. But the fact that in India, unlike in England,

there were no legal proscriptions on birth control helped matters considerably. Indeed as the Census Commissioner, appreciating the work of the Neo-Malthusian League in Madras, wrote in 1932:

> A definite movement towards artificial birth control appears to be taking place, perhaps less hampered by misplaced prudery than in some countries which claim to be more civilized; thus not only is artificial control publicly advocated by a number of medical writers, but Madras can boast of a Neo-Malthusian League, with two Maharajahs, three High Court judges and four or five men very prominent in public life as its sponsors. (Hutton cited in Srinivasan, 1995: 16)

What is also extremely interesting is that in this discourse the troubled, indeed fraught ideas of Indian womanhood that had informed a range of nationalist debates in the nineteenth century, from age of consent to *sati*, had been eclipsed. In the colonial period, Indian women had been objects of nationalist reformist agendas setting right what were conceived as the aberrations of the recent past; practices such as widow immolation and child marriages were evidence to the British that they did indeed have a civilising mission among the barbaric and traditional Hindus. Extremely contentious debates had arisen about the new or modern Indian woman to be brought into being in a new Indian nation; a woman who was to be distinguished both from the materialistic un-godly Western woman and the superstitious and sexually promiscuous common Indian woman (Chatterjee and Riley, 2001: 811). This modern woman was to be a good woman, a chaste wife, a good mother, enlightened yet spiritual, who would participate in nation-building by harnessing children as resources.

In the unanimity that prevailed about the need for population control, two remarkable men, however, stand out sharply—Mahatma Gandhi and Periyar. Gandhi was opposed to birth control because he believed that society would be enervated, weakened, by birth control. 'The sex urge', he wrote, 'is a fine and noble thing ... but it is meant only for the act of creation. Any other use of it is a sin against God and humanity' (cited in Srinivasan, 1995: 18). He dismissed Margaret Sanger's arguments for contraception on the grounds that it increased self-indulgence. Thus he wrote:

> It is certain that excessive indulgence increases the rate of infant mortality. People in the West limit births, not with any religious idea,

> to be sure, but for reasons of health and for fear of having to bring up too many children. For us such is not enough .... We in India lay great claim to being more religious in our lives than people in the West, and yet we ignore the restraints imposed by religion. Hence it is that many parents, regardless of both dharma and worldly considerations, remain steeped in carnal pleasures and bring forth children regardless of circumstances. The result, whether we want them or not, diseased children are born and die in their infancy. (Gandhi, 1920: 469)

When Sanger wrote to him, pleading for birth control on the grounds of the suffering imposed on women by frequent pregnancies, he was rigidly unbending, befitting a patriarch of a Hindu joint family. He replied:

> I agree that there are hard cases. Else, birth control enthusiasts would have no case. But I would say, 'Go and devise remedies by all means, but the remedies should be other than the ones you advise.' I carry on correspondence with many of these people and they describe their ailments to me. I simply say that if I were to present them with this method of birth control, they would lead far worse lives. (cited in Srinivasan, 1995: 19)

That he did influence the NPC's Sub-Committee on Woman's Role in Planned Economy is evident in their compromised observation:

> Self-control is the best method for those who can exercise it without ill effects to their health. But this is a method which we cannot offer to the average man and woman and hence knowledge of scientific methods of birth control must be made available for those who desire it. (NPC, 1948c: 203)

Periyar's views were strikingly at variance. He rejected eugenic and neo-Malthusian arguments on entirely rational grounds, but equally strongly argued for birth control for women, to enable them to control their own lives, to break servitude to patriarchy, to caste, and indeed the family. Thus he wrote:

> There is a fundamental difference between our reasons for the necessity of contraception and those of others. That is, we say contraception is essential for women to be free and autonomous. They say it is essential for women's health, national economy and to prevent

> fragmentation and destruction of family property. First of all, whether a woman needs birth control or not should be entirely a woman's decision. Secondly, the objective of birth control is not to control the growing population or to advance the economy, but to create an environment for women to have rights and decision making power. (cited in Anandhi, 2000: 155)

In the event, of course, neither Periyar, whose views adumbrated with startling relevance indeed with contemporaneity, nor Gandhi's views, influenced policy. We find thus two compelling—if not necessarily complementary—concerns shaping the emerging population policy. The first related to the benefits accruing to national development, what was to become the familiar neo-Malthusian refrain; and the second, to the benefits accruing to women's health through birth control. While not contesting the latter, it is nevertheless important to note that this emphasis on women as reproductive beings whose 'tired reproductive machinery is automatically set in motion by reproductive act', is an abiding concern with policymakers. This concern does two things: first, it focuses on women primarily as reproducers, ignoring all their myriad productive activities that indeed contribute to national development. Second, it serves to isolate reproduction from the socio-economic context within which it occurs. The effort can then be to alter this through reproductive technology directed towards a woman whose reproductive profligacy is posited as the primary cause for her poverty and ill-health. What this approach fails to take cognisance of, is that of the various causes of maternal deaths in the reproductive age group, only a relatively small proportion are related to pregnancy and child birth. Even within the reproductive age group in women, the major causes of death are infectious and communicable diseases and anaemia. These are not, of course, responsive to birth control.

In other words, birth control is not posited as a woman's right as a citizen but as a means to either national development or the reduction of extraordinarily high maternal mortality rates. It is nevertheless important to note that women's right to contraception in India was not an outcome of protracted battles on the part of women as in the countries of the West. This was no doubt due to the fact that a neo-Malthusian concern with overpopulation as the cause of India's poverty was overwhelmingly accepted among influential sections of the population, as indeed they were by India's colonial masters.

THE FIRST FIVE-YEAR PLAN (1951–56)

The famous Health Survey and Development Committee, eponymously and commonly known as the Bhore Committee, was established in 1943 to provide a blueprint for the development of health services in the country. Inspired partly by the Beveridge Committee in England that set up the backbone for the welfare state, and partly by, the remarkable advances in health made by the then revolutionary Soviet Union, the Committee was equally revolutionary in its outlook and recommendations. The perspective of the Committee could arguably be described as the forerunner of the 'Health for All' strategy that was to crystallise around the globe several decades later. Health was recognised as a right of all citizens, irrespective of their ability to pay. The Committee recognised also that health was an outcome of interventions in a large number of fields such as employment, incomes, food and so on. It was of the opinion that notwithstanding financial constraints, the state could, and ought to, invest 10 per cent of its resources on health if a dent was to be made in the disease and death profile of the country. The health structure recommended was to have a rural focus and a preventive bias, in keeping with epidemiological priorities. Finally, the Committee called for a health structure essentially dependent on paramedical personnel, guided and led by a 'social physician'.

These bold initiatives notwithstanding, the Bhore Committee trod no new ground when it came to family planning. Noting that declines in birth rates had not followed declines in death rates, the Committee concluded that India was indeed confronted with a population problem that could have grave consequences as 'uncontrolled growth of population would outstrip the productive capacity of the country' (Government of India [henceforth GOI], 1943: 483). The Committee recommended assistance by the state to the birth control movement, both on the grounds of the health of mothers and on economic grounds, in the interests of the individual and the community. The doleful imprint of the eugenics movement is obvious in the Report's observation that:

> ... the classes which possess many of these undesirable characteristics are known to be generally improvident and prolific. A continued high birth rate among these classes, if accompanied by a marked fall in the rate of growth of the more energetic, intelligent and ambitious sections

> of the population, which make much the largest contribution to the prosperity of the country, may be fraught with serious consequences to national welfare. (GOI, 1946: 487)

Although the newly independent GOI accepted the recommendations of the Bhore Committee, this was not reflected in its commitments during the following years. Indeed allocation for health was far below that recommended by the Bhore Committee and continued to decline over the years. Despite the Bhore Committee's recommendations to evolve a health structure with a rural focus, largely dependent on paramedical personnel, what emerged—indeed was assiduously created—in India was a doctor-based, urban biased health care system. These were of course not simply fortuitous developments, but reflected political decisions of priorities set and of funds allocated. These distortions commenced in the First Five-Year Plan itself. On the question of population, however, the First Plan was more thoughtful and cautious.

> It is not possible to judge whether or not an increasing population is favourable or unfavourable to development. In the past, periods of rapid economic development have also been periods of rapidly increasing population, but whether or not there is any causal relationship between the two or how it works, one cannot say with any certainty. In periods of rapid development and changing techniques, it is questionable whether the concept of 'optimum' population can have any precise meaning. (GOI, 1952: 18)

Nevertheless, this caveat notwithstanding, the Plan added inexplicably:

> The pressure of population in India is already so high that a reduction in the rate of growth must be regarded as a major desideratum. To some extent, improvement in living standards and more widespread education, especially among women, will themselves tend to lower the rate. But positive measures are also necessary for inculcation of the need and techniques of family planning. (ibid.)

The official programme for family planning was launched in 1952 with a modest budget of Rs 6.5 millions. Thus India has the distinction of being the first country in the world to have an official family-planning policy and programme (Demerath, 1976). The principal measures envisaged were:

(*a*) the provision in government hospitals and health centres of providing advice on methods of family planning;
(*b*) field experiments on different methods of family planning for determining their acceptability and effectiveness; and
(*c*) the development of suitable procedures to educate the people on family-planning methods (Bose and Desai, 1974: 184–92).

This Clinic Approach was largely passive, based on the presumption that there existed sufficient unmet demands for family-planning services. That the planners were not quite convinced of the efficacy of this approach was also indicated by the fact that the programme was also meant to educate, not inform, people on family-planning methods.

The Ford Foundation 'played an active and innovative' role in these developments. In 1952, the Ford Foundation's representative in India informed Prime Minister Jawaharlal Nehru that his organisation considered 'India's rapid population growth a major problem and was willing to consider appropriate aid in this field' (Minkler, 1977a: 404).

During the period of the First Plan, 21 rural and 126 urban family-planning clinics were established (GOI, 1961a). But India's family-planning programme was already receiving international attention. Private international agencies rushed in with funds, consultants, and technical advice. The Ford Foundation granted $9 million (Mass, 1974: 651–74). According to Bonnie Mass, the Foundation

> ... chose India as a target for intensive research in demography, contraceptives and distribution systems, thereby following in the path of the Population Council which made a grant to India's Institute of Public Health for a field study of population control in West Bengal. (ibid.)

The Ford Foundation's involvement, it is stated, 'firmly established the Foundation in India as an innovator working in the threshold of programme development in the population arena'. The Ford Foundation helped create two of India's major institutions involved in the family-planning programme, namely, the Central Family Planning Institute, later rechristened the National Institute of Family Planning (NIFP), and the National Institute for Health Administration and Education (NIHAE) (Minkler, 1977a: 404).

It is not possible to understand the Indian family-planning programme without reference to the international actors who set the agenda, primarily in the United States (US). Indeed it has been argued that 'a small group of men and women' in the US, many of them bankrolled by the Rockefeller Foundation, gave shape to the global population movement (Connelly, 2003: 128). The post-War population control movement comprised a closely-knit group of public and private organisations including the Rockefeller Foundation, the Population Council, the Ford Foundation, and the USAID, along with its counterparts in other Western countries. Multilateral institutions, which followed the agenda set by these institutions at a later stage, included the United Nations Fund for Population Activities (UNFPA) and the World Bank.

During this period was launched the very influential Khanna Study in Punjab, on which more later.

THE SECOND FIVE-YEAR PLAN (1956–60)

The Second Plan noted:

> Regarding population growth, only a few observations seem necessary. Rates of population growth can be altered only over a period ... one has to go by the results of trends which commenced earlier. Nevertheless, over a period, the outcome of development effort can be noticeably different if population trends are altered in the right direction. This is one of those fields in which traditional modes of thought and behaviour are apt to offer considerable resistance to rational approaches and not many countries can be said to have any definite population policy at government level. Yet, these modes or attitude are changeable and are probably changing faster than is sometimes realised. The logic of facts is unmistakable and there is no doubt that under conditions prevailing in countries like India, a high rate of population growth is bound to affect adversely the rate of economic advance and living standards per capita. Given the overall shortage of land and of capital equipment relatively to population as in India, the conclusion is inescapable that an effective curb on population growth is an important condition for rapid improvements in incomes and in levels of living. This is particularly so, if one bears in mind that the effects of improvements in public health and in the control of diseases

> and epidemics is to bring about an almost immediate increase in survival rates. While there may be differences as to the likely rates of population growth over the next 20 or 25 years, indications clearly are that even the utmost effort which can be made—and has to be made—at this stage to bring down birth rates, population pressure is likely to become more acute in the coming years. This highlights the need for a large and active programme aimed at restraining population growth, even as it reinforces the case for a massive developmental effort. (GOI, 1956: 7)

What seems amazing in hindsight is the utter confidence underlying many of the assumptions in the Plan, although it admitted that it lacked experience. The Plan felt that tradition and modes of thought would change, 'population pressure', never appropriately defined, would be brought down, incomes would increase and a brave new world would dawn with the adoption of birth control technologies. What is singularly curious is the complete dissociation from the determinants of population: health and survival, food, employment, incomes and so on. It was assumed that population was the major stumbling block to economic development, just as it was assumed that an irrational population simply did not know what was in its own interests. What was equally interesting is that another country, comparable to India, was also embarking upon development, including provision of health and family-planning services at this time. China attempted to do this through land reforms, provision of food security, universal health services, employment, and investment in human development (Drèze and Sen, 1989).

Perusing these developments over the first two Plan periods, there appears to be a clear shift of perspective regarding the issue of the relationship between socio-economic and demographic changes. While the First Plan noted, quite correctly, that in the past there had been periods when population growth was accompanied by economic development, and that it was not always possible to determine the relationship between these phenomena, the perspective was evidently one that envisaged demographic changes as dependent variables, responding to wide-ranging shifts in social structural factors. It did not indicate, therefore, that attempts at control and manipulation of fertility alone would be either necessary or feasible. That is to say, there was recognition of the fact that the issue was complex and had wider determinants.

The Second Plan, on the other hand, appeared to indicate that population growth was an independent variable and economic development

the dependent one, overturning a perspective that emerged out of years of demographic research. It is perhaps accidental that this change of perspective was actively being worked upon and current in the field of demography in the US during this period. As we shall see in Chapter 2, earlier efforts towards understanding so complex a phenomenon as the relationship between population dynamics and socio-economic change had undergone a transformation towards a policy prescription for Third World countries (Hodgson, 1983: 20).

In the Second Plan, allocation for family planning increased remarkably even as health sector expenditure declined. Thus, family planning was allotted Rs 50 million while health was allotted a budget of Rs 2.25 billion, out of a total Plan outlay of Rs 46.72 billion. This represented 0.10 and 4.81 per cent respectively of the Plan outlay for family planning and health (GOI, 1961b: 404). In 1956, after little progress during the First Plan, and following the widely disseminated remarks of the Census Commissioner about what he called improvident maternity, the first official planning groups and blueprints were established on a national scale (Cassen, 1978). The Central Family-Planning Board, chaired by the Minister of Health, was established. By 1959, State Family-Planning Committees were set up in all states. No such effort was visible in the field of health. Officials were appointed to all these posts: at the Centre, a Director of Family Planning responsible to the Director General of Health Services. In other words, the institutional structure for a separate, and powerful, vertical programme was established.

During this Plan period, 1,079 rural and 421 urban clinics came into existence. About a hundred of these were set up in association with medical colleges and training centres for medical auxiliaries. Training, education, and research received a fillip. Contraceptive research commenced at research centres in Mumbai, the All-India Institute of Hygiene and Public Health in Kolkata, and the Central Drugs Research Institute in Lucknow. A Demographic Training and Research Centre was established in Mumbai in 1956. In addition, three Demographic Research Centres were set up in Kolkata, Delhi, and Thiruvananthapuram (GOI, 1961a: 404). Field training centres, run by the Ministry of Health, were established at Mumbai, Ramanagaram in the then Mysore state, and in Delhi, even as many state governments set up their regional training centres. A pilot training team was formed by the Family-Planning Association of India, a non-governmental organisation (NGO) which has been profoundly

influential in shaping family-planning policies and programmes. Instruction in family-planning methods was incorporated in the curriculum for doctors and nurses. Indeed, even school teachers were mobilised in various states and provided orientation training under the Community Development Family Planning Scheme (GOI, 1961a).

The operational strategy of the family-planning programme during the first two Plan periods was influenced by the approach of the international planned parenthood movement (Banerji, 1976: 665). The family-planning clinics that had been opened emphasised person-to-person instruction on contraceptive methods, based on the philosophy that it was physically possible and morally desirable for couples to control the size of their families; and that limiting the number of children in a family was good for the society whose general welfare was endangered by rapid population growth (Demerath, 1976).

THE THIRD FIVE-YEAR PLAN (1961–65)

In order to assess the progress that had been made since the Bhore Committee, the GOI appointed the Health Survey and Planning Committee, popularly referred to as the Mudaliar Committee. The Report of the Committee, published by the Ministry of Health in 1961, observed that the recommendations of the Bhore Committee were 'faltering and half-hearted' in relation to family planning. It recommended that 'if the family planning movement is to produce early and effective results, it has to be in the nature of a mass movement' (GOI, 1961a: 405). The Committee was, therefore, of the view that far more attention had to be paid to family planning than had hitherto been the case. To this end they recommended a series of measures commencing with the strengthening of the Health Ministry, greater cooperation with voluntary organisations such as the Family-Planning Association of India, and according high priority to the production of contraceptives. They also recommended that family planning should be an essential part of the activity of all health agencies (GOI, 1961a: 675).

Perhaps of greater interest is the Supplement to this Report. Reflecting a sense of urgency bordering on panic, a Minority recommended the consideration of 'appropriate legislative and administrative measures' in view of the urgency of the problem, to ensure a fall in

the birth rate of the country during the next five years. The measures suggested included:

(*a*) graded tax penalties from the fourth confinement onwards;
(*b*) removal of income tax disadvantages for single persons;
(*c*) withdrawal of maternity benefits for those refusing to accept family limitation;
(*d*) limitation of certain government services such as free education, to three children per family;
(*e*) enlisting the participation of government employees in promoting family planning; and
(*f*) abortion for socio-economic reasons.

The Minority Report foreboded, in a sense, the shape of things to come: the iron hand of coercion behind the velvet glove of rhetoric. This was the beginning of a period in the West when a sense of doom and panic was being created with reference to the 'population bomb' ticking away in Third World countries, posing not only a threat to themselves but to the entire world. What was being suggested was that all efforts at development in newly independent countries were doomed to failure unless the issue of population growth was tackled on a war footing.

Many of the elements of the Minority Report were to enter the discourse on family planning and into policy repeatedly over the years. What is astonishing is that so soon after the dawn of Independence, the glow of its promise seems to have faded. Indeed, that influential sections of the people could consider linking citizenship rights to the family-planning programme draws attention to various atavistic fears and anxieties related to the reproductive behaviour of the 'poor'.

The Third Plan document, reflecting the recommendations of the Mudaliar Committee, accorded 'very high priority to family planning' and noted that:

> ... the objective of stabilising the growth of the population over a reasonable period must be at the very center of planned development. In this context, the greatest stress has to be placed in the Third and subsequent Five Year Plans on the programme of family planning. This will involve intensive education, provision of facilities and advice on the largest scale possible and widespread popular effort in every rural and urban community. (GOI, 1961b: 675)

The emphasis on the family-planning programme as the centre of planned development received impetus from the results of the 1961 Census which showed a higher rate of population growth than expected. It was also due to the increasing interest shown by Western aid agencies in the programme. It resulted in the burgeoning of the programme. As against an outlay of Rs 6.5 million in the First Plan and Rs 50 million in the Second Plan, the outlay for family planning in the Third Plan was Rs 0.5 billion: health obtained an outlay of Rs 3.42 billion.

However the limitations of the clinic approach were now being highlighted. In April 1963, the director of Family Planning, advised by a Ford Foundation consultant, initiated a reorganisation (Demerath, 1976). The reorganised programme was to emphasise extension education, greater availability of contraceptive supplies, and less dependence on the traditional clinic approach. The move way from the passive clinic approach to the more active extension approach again emanated from the community development movement in the US (Banerji, 1985). Indeed, this had been the inspiration to India's own efforts at community development in general and agricultural extension education in particular.

The main programme goal was the reduction of the country's birth rate from more than 40 per 1,000 to 25 per 1,000, possibly by 1973. It is ironic, and indicative of the fundamental flaws in the population policy that persist to this day, that this level is yet to be reached. To achieve this, the operational goals were defined as achieving, for 90 per cent of the married adult population, three basic conditions, namely:

(*a*) group acceptance of the small family size norm;
(*b*) personal knowledge of specific birth control methods; and
(*c*) easy availability of supplies and services (Raina, 1988: 60).

The result was a massive expansion of the programme organisation. This included the creation of the posts of parivar kalyan sahayaks and sahayikas, the addition of auxiliary nurse midwives (ANMs) and male family-planning fieldworkers, and an additional woman doctor, exclusively for family planning, a block extension educator at the primary health centre level. Full fledged family-planning bureaus were established at the district level. Family-planning organisations at the state and at the centre were concurrently strengthened.

The primary health care system, which as the Mudaliar Committee noted, bore no resemblance to that visualised by the Bhore Committee, received an organisational shot in the arm due to the compulsions dictated by family planning. This was not, of course, an unmixed blessing as the PHC system became inextricably linked not to the health of the people but to family planning. Thus the PHC system had as its family-planning personnel, besides a lady doctor, ANMs, extension educators, health assistants (one per 20,000 population), lady health visitors (one per 40,000 population) as well as statistical and other staff. At the grass roots, the sub-centre per 5,000 population was to staffed by an ANM, 'the infantry of the programme'[1] (Raina, 1988: 65). The central government committed itself to bearing the entire expense of the family-planning programme in the states, although the rest of the primary health centre staff remained on the states' budgets (Cassen, 1978: 185).

As steps were being initiated to implement the reorganised programme, the United Nations Advisory Mission visited India in 1965 and suggested the launch of a 'reinforced programme' parallel to the former. Three courses of action were recommended under the reinforced programme, namely, an energetic loop (IUCD) programme, an intensified sterilisation programme, and the promotion of the use of condoms through wider availability via commercial channels. These recommendations shifted the focus from the reorganised programme with an extension education approach, to a forceful loop programme (Raina, 1988: 65). It has been noted that

> ... the designer of the model of the IUCD which was employed at the outset, Mr. Jack Lippes, and other foreign experts visited India and were instrumental in persuading the Government that it was suitable for widespread use. The first U.N. Mission, which examined the family planning programme in 1964, had a major role in this respect. (Cassen, 1978: 149)[2]

The role of the UN Family Planning Mission in 'endorsing' the loop was acknowledged in the Report of the Second Mission (UN, 1969). The Report of the First Mission commended 'the intra uterine device' for it 'offers at present the best possibilities for large scale, successful programmes for reducing the birth rate in the country. The plastic loop convinced the Mission that every effort should be made to distribute it in a wide scale' (ibid.: 90).

At its first meeting in December 1965, the newly established Central Family-Planning Council recommended the formation of a committee 'to review what additions and changes are necessary as a result of the greatly altered situation due to the IUCD having come to the forefront of the programme, in the staffing pattern, financial provisions etc' (GOI, 1966: 1). The Mukherjee Committee, which thus came into being, noted that 'on account of the IUCD method becoming available, a mass programme has become feasible on account of this methods very great clinical and administrative advantage over sterilisation' (ibid.: 1). The Committee recommended a separate and significantly strengthened staff to be in full-time and overall charge of the family-planning programme implementation. Startling, and unique to the programme, was the establishment of targets fixed for various levels for each of the components of the programme, with a special emphasis on the IUCD. This too was a step suggested by foreign experts. The Committee also recommended the establishment of a mobile sterilisation and a mobile education and publicity unit attached to each district family-planning bureau. So anxious was the Committee to meet the targets fixed that they recommended the sanction of incentives—at the behest of foreign experts[3]—to both the health personnel and to individuals undergoing sterilisation or accepting IUCD insertion. The Committee noted that their recommendations received corroboration from the Evaluation Report of the World Bank (the Bell Mission Report), the UN Evaluation Report, and the Report of the Family-Planning Programme Evaluation Committee.

Far from facing superstitious suspicion from the people, the remarkable ease with which the IUCD was introduced into the programme, given the health of women in the country at that time, and the almost complete absence of health services during that period, testifies to the anxiety with the population issue. It also testifies to the penchant, still current, to find easy or quick technical solutions to complex social problems. Indeed as Demerath, who worked as an expert in India's family-planning programme in the 1960s, before biting the hand that fed him, observed 'the first reason why family planning fails is the obsession of the experts with the techniques of contraception. The belief that just about any problem can and will be fixed by some new tool or technique is as Anglo-American as apple pie' (Demerath, 1976: 90).

It is not surprising that the Estimates Committee of the Lok Sabha in their *Thirteenth Report on the Family Planning Programme* (1971–72) observed:

> The Committee regrets to note that the IUCD programme was formulated and implemented on the advice of foreign advisers without analyzing its pros and cons and without exercising an independent judgement on its suitability in Indian conditions and without establishing any proper infrastructure for the same. The Committee suggest that a critical evaluation of the foreign assistance rendered so far may be undertaken and that in the light of past experience, foreign assistance be accepted only when necessary. (cited in Bose, 1988: 42)

This was the period of about the greatest, most obvious, involvement of foreign donors and international experts. What is curious is that although the proportion of finances from international donors has never been significant—never, ever, exceeding a tenth of the total health budget, they have exerted a disproportionate share of influence. The greatest foreign involvement came after the droughts and economic crises of 1966 when the World Bank pressurised the Indian government to intensify population control measures and the USAID replaced the Ford Foundation as the leading agency providing assistance to population control in India (Harkavy, 1995). Indeed foreign advisors were described as being 'at the elbows of Indian administrators' (ibid.: 143). Bose notes: 'For over a decade American experts not only dominated the Family Planning Department but were also involved in the routine administration of family planning' (Bose, 1988: 41).

But, of course, the problem was more than just the foreign nationality of the experts. In 1965–66, the Programme Evaluation Organisation of the Planning Commission evaluated some aspects of the implementation of the family-planning programme and made far-ranging recommendations (Banerji, 1985) that were in line with the recommendations of the World Bank and the UN. At the Centre, the Report emphasised the need for more administrative and financial authority and a greatly strengthened headquarter staff with sections on planning, contraceptive supplies, administration, training, and education, and of field operations with six regional officers. It was recommended that a Central Family-Planning Organisation be established

as a Directorate General in the Health Ministry. The Director General of Family Planning was to be called the Commissioner of Family Planning and be ranked an ex-officio Additional Secretary to the government. In December 1965, soon after the new Prime Minister took office, the Ministry was designated the Ministry of Health and Family Planning. These were more than symbolic moves: they indicated the real importance attached to family planning. Indeed this was one programme that could not henceforth be characterised as lacking in political will or one marked by a failure of implementation.

In short, then, the Third Plan period witnessed the burgeoning of the family-planning programme even as it showed several shifts of policy, strategy, and emphasis. Family planning came to dominate concerns in the field of health and increasingly contoured the directions of health policy. At the end of the Third Plan there were 3,676 rural family-planning centres, 7,081 rural sub-centres, and 1,381 urban family-planning centres. In addition, 450 family-planning annexures to primary health centres were established and 2,770 sub-centres constructed.

In view of the serious economic crisis plaguing the country, partly on account of the debacle with China on the border, and partly on account of several consecutive bad monsoons and the consequent fall in food production, Annual Plans were adopted in the years 1966–69 instead of Five-Year Plans. This, however, was not allowed to affect the population policy. Indeed, financial allocations to the programme continued to increase. During these years, health obtained an allocation of Rs 1.4 billion, family planning obtained an outlay of Rs 0.75 billion, compared to Rs 2.25 billion and Rs 249 million respectively in the Third Plan. This was a three-fold increase for family planning in just three years (GOI, 1969: 391).

In April 1966, family planning was withdrawn from the purview of the Directorate General of Health Services (DGHS) and constituted into a separate Department of Family Planning in what was then called the Ministry of Health, Family Planning, and Urban Development. It has been suggested that this step was taken primarily to impress the World Bank and other aid agencies (such as the Aid India Consortium), with a view to obtaining greater financial support (Raina, 1988: 71). In other words, this step was taken to demonstrate to prospective lenders, seriously concerned with India's population problem, that she was doing something about it equally seriously, indeed forcefully.

During this period, when India first approached the World Bank for loans, the World Bank was very interested in the population policies of developing countries that were prospective borrowers:

> All such activity (in regard to family planning programmes) arises out of the concern of the Bank for the way in which rapid population growth has become a major obstacle to social and economic development in many of our member states. Family planning programmes are less costly than conventional development projects. (Mass, 1974: 665)

Again, in line with the recommendations of the first UN Advisory Mission of 1966 that the Directorate of Family Planning 'should be relieved from the other responsibilities such as maternal and child health and nutrition' (UN Advisory Mission cited in Banerji, 1985: 285), Maternal and Child Health (MCH) activities were de-linked from family planning in order to enable fieldworkers to concentrate on family planning. This recommendation arose out of the 'fear that the programme may be otherwise used in some states to expand the much needed and neglected maternal and child welfare services'. This was particularly ironic as the very justification for family planning was that it profoundly affected and shaped the health of women and children. Yet, in the high tide of fears of the 'population explosion' in Third World countries, this foundational argument was brushed aside to concentrate on family-planning goals.

Enthusiasm for the IUCD programme now ran so high that policymakers, and academics, were beginning to calculate how many years the programme would have to continue before the 'problem was eradicated'. In 1966–67, over 900,000 women were fitted with IUCDs. In the following year, the number declined to 669,000 in spite of the best of efforts, on the part of health care workers, and from then on the decline was quite drastic. In other words, the IUCD strategy proved to be a failure. This was no doubt related not so much to the technology itself as to the inability of the system to screen suitable women and provide guidance, counselling, and follow-up. It was also no doubt related to the targets that placed a premium on numbers.

The assumption over these years appears to have been that family planning was a necessary outcome of contraceptive technology alone and that sufficient unmet demand existed among the primarily poor agricultural population of the country. This latter assumption was no

doubt strengthened by the plethora of KAP (Knowledge Attitude Practice) studies that were undertaken.

Following trials in 1967 and 1968, the Nirodh Marketing Programme was launched in September 1968. Inspired by a marketing specialist from the Massachusetts Institute of Technology (MIT), the scheme utilised the marketing outlets of Brooke Bond, Lipton, Indian Tobacco, Hindustan Lever, Tata Oil Mills, and Union Carbide to reach over 2 million potential retail outlets (Cassen, 1978). And in August 1967, the Indian Council of Medical Research (ICMR) recommended the introduction of oral pills on a pilot basis.

THE FOURTH FIVE-YEAR PLAN (1968–74)

The Fourth Plan document noted that the problem of population had, in fact, grown even more acute (Mitra, 1974). The birth rate, it noted, 'appears to have remained unchanged around 41 per thousand during the greater part of the past two decades' (GOI, 1969: 391). The Plan accordingly held that the programme of family planning had assumed national importance warranting the highest priority.

> Population growth thus presents a very serious challenge. It calls for a nationwide appreciation of the urgency and gravity of the situation. A strong purposeful Government policy, supported by effective programme and adequate resources of finance, men and materials is an essential condition of success. (ibid.)

The Plan noted that the population growth rate was estimated to be 2.5 per cent per annum and that 'in order to make economic development yield tangible benefits for the ordinary people, it is necessary that the birth rate be brought down substantially as early as possible. It is therefore proposed to aim for the reduction of the birth rate from around 39 per thousand to 25 per thousand within the next 10–12 years' (ibid.). The Draft Plan outlay of Rs 3 billion was revised upwards to Rs 3.15 billion so that the programme could be strengthened and speeded up; health obtained an outlay of Rs 4.335 billion.

The Fourth Plan proposed 'to step up the target of sterilisations and IUCD insertions and to widen the acceptance of oral and injectable contraceptives'. Further

> For intensifying the family planning programme, new schemes like the post-partum programme, supply of surgical equipments to hospitals, intensive district and selected area programmes, supply of vehicles at primary health centers have been included for implementation during the Fourth Plan. (GOI, 1969: 394)

The pace of the programme was thus substantially accelerated; a sterilisation target of 14.9 million was fixed (Raina, 1988). The efforts of rural and urban family welfare centres for vasectomy operations were to be supplemented by more than 1,000 mobile service units attached to district family-planning bureaus.

Thus vasectomy, which had been practiced in India in family planning clinics for a considerable time (it was, for example, available in the then state of Madras in 1955) received great official impetus. Given the failure of the IUCD approach, vasectomy came to occupy centre stage in the family-planning programme. Several 'ingenious' initiatives were undertaken. Dr D.N. Pai established a vasectomy clinic described as 'one of the most successful of the early programmes' at Mumbai's Victoria Terminus station, to cater to the railway passenger traffic of the order of 200,000 or more people every day (Cassen, 1978).

Possibly inspired by Pai's work in Mumbai, S.S. Krishnakumar, Collector of Ernakulam district in Kerala, organised what has been described as a historic vasectomy camp in the Ernakulam Town Hall in December 1970. It has been observed that whereas Dr Pai brought vasectomy to the crowds, Krishnakumar's feat was the he brought crowds to the operation. An extensive publicity campaign preceded the camp; transport was provided to ferry the patients; and a large incentive, including gifts in kind, was offered along with a lucky dip with substantial prizes. Indeed the enthusiastic Collector created a 'festive atmosphere' at the camp. The result was the 'remarkable achievement' of over 15,000 vasectomies in one month.

Mr Krishnakumar was determined to prove the value of his method and organised a second camp in July 1971, drawing on a wider region for clientele. Over 63,000 vasectomies were performed in this camp that received a striking place in the annals of India's family-planning history. As a result of the Collector's efforts, of the total number of vasectomies performed in Kerela in the whole year, 42 per cent were performed in Ernakulam in one month alone. In three camps organised between 1970–72, approximately 14 per cent of

couples in Ernakulam in the reproductive age group were sterilised. The same proportion was achieved in Kerala as a whole in the six years between 1965–71.[4]

The World Bank, the UNFPA, and Swedish International Development Agency (SIDA) supported these 'dynamic' initiatives with considerable funds. Indeed there was great excitement in the corridors of the population establishment in New Delhi, New York, and Washington, when, against a target of 30,000 'cases', the Collector achieved 65,000 (Banerji, 1985: 243).

The Department of Health and Family Planning was now becoming convinced of the efficacy of the camp approach and states were encouraged to hold camps. Gujarat managed to steal Kerala's thunder by achieving 160 per cent of its annual target in little more than two months (Thakore and Patel, 1972: 186). The districts, vying with each other, were encouraged by newspapers that published score-boards, much as in the case of cricket matches, to show which districts were leading in this game of numbers. So convinced were the middle classes by now that overpopulation lay at the heart of all social and economic problems facing the country that employers such as the railways and associations such as the Chambers of Commerce and the Rotary Club competed with each other to assist in organising vasectomy camps. By 1972–73, most states were holding camps, although in several states where attempts were made to hold repeat camps, the performance was dismal. At a camp in Gorakhpur in Uttar Pradesh in 1972, 11 men who had undergone vasectomies died of tetanus (Cassen, 1978).

In 1972–73, 3.1 million sterilisations were performed in India, a figure exceeding the number of sterilisations achieved in previous years. Two-thirds of these were performed at camps. In 1973–74, the figure was down to 0.94 million. By 1974, despite statements in favour of a suitably modified camp approach (GOI, 1975a), the Department of Health and Family Planning had abandoned its emphasis on the camp approach. This was partly a result of the disasters such as that which took place at Gorakhpur and the subsequent setback. It was also partly due to the problems experienced in sustaining the camp approach (Greer, 1984: 352) and the financial stringency of the period.

Meanwhile, in 1971, the Medical Termination of Pregnancy (MTP) Act was passed, which legalised abortion carried out by recognised practitioners on medical grounds. The inclusion among the grounds

for eligibility of failure of a contraceptive device made abortion more or less available on demand. To increase the number of trained personnel, the government undertook training of doctors in MTP techniques in medical colleges and district hospitals. What is interesting to note is that although abortion was a demand bitterly fought for by the women's movement for almost a century in the West, it was in a sense given on a platter in India. This is, of course, not to diminish its importance, nor indeed question the need for this measure, but to draw attention to the fact that it was the over-riding importance attached to controlling numbers that led to this progressive legislation. That abortion is still vastly inaccessible is another sad story. What is also to be noted is that in what is often described as a religious civilisation, there was hardly any opposition to the legislation.

Another programme initiated during this period was the All-India Hospitals Post-Partum Programme. It commenced in 1969–70 with the objective of providing advice and services to obstetric and abortion cases in hospitals and to provide training in family planning. It was envisaged that contraceptive services and family-planning education would be provided under the programme to the community in the vicinity of hospitals.

In addition to these initiatives, the GOI, in collaboration with the USAID launched the Intensive District Programme (UN, 1969). This involved the provision of additional inputs to undertake campaigns in the 46 most populous districts in the country.

At the same time, things were not going well with other health programmes. What had started as a trickle of a setback to the National Malaria Eradication Programme in the Third Plan became a veritable flood in the Fourth Plan, as there occurred an upsurge of malaria cases all over the country. The incidence of malaria reached a plateau between 1971 and 1976; and from 1974 onwards, deaths due to malaria started increasing. While the number of cases declined subsequently, the toll of deaths due to malaria continued to increase.

Following a series of smallpox epidemics, an entirely new approach was adopted in the smallpox eradication programme. This finally started paying dividends and India finally eradicated smallpox in 1975. However, it is important to note that when the vertical programme for the eradication of smallpox was launched in the First Plan, it had been envisaged that the disease would be eradicated by 1962. In the event, not only had more resources been poured into this programme than had been envisaged, draining thereby the budget for

the development of health infrastructure, it also earned India the dubious distinction of being one of the last countries in the world to eradicate this disease. In parenthesis, it might be noted that the eradication of smallpox was possible because of the epidemiological uniqueness of the disease.

The seeming defeat of the malaria eradication programme and the setback to the family-planning programme together contributed to increasing demands for resources—both human and financial—from the vertical programmes. Considering this disquietening, the government appointed the Kartar Singh Committee to consider the question of integrating the vertical programmes that had become unsustainable and indeed ineffective. The Kartar Singh Committee felt that integration would be economical and feasible and went on to recommend the integration of the programmes. The workers of these programmes, were to be re-trained and to be designated as multipurpose workers (GOI, 1973).

To sum up, the Fourth Plan period witnessed, as in the Third Plan period, very concerted efforts to consolidate the family-planning programme, even as it witnessed shifts in programme strategy and emphases. Nevertheless, towards the end of the period, it was increasingly being realised that the approach hitherto adopted had not yielded commensurate returns, indeed that the programme had reached a cold dead end. It was noted that

> ... in 1974 the family planning programme had reached a state of financial and even philosophical disarray. With the total number of acceptors in 1973–74 down 27 per cent on the previous year, things looked gloomy for the programme. (Cassen, 1978: 174)

At the same time, international agencies were increasingly growing aware of the failure of the family-planning approach to poverty. It seemed that almost everything had been tried that could be tried. There had been no dearth of expertise or funds or indeed that famous bugbear of Indian development, political will. Disenchantment was widespread and some of the hawkish disenchanted called for more coercive forms of population control. The dovish ones, pointing out to the futility of coercion, felt that there had to be efforts towards dealing with poverty. They called for redirecting development benefits to the impoverished to hasten their adoption of the small family norm. It was these factors that led to some rethinking, to calls for a

broad-based development approach (Hodgson, 1988). Towards the early 1970s, it was increasingly being realised that the technology-centred model of health sector development had led the country down a blind alley. Given the failures of the malaria eradication programme and indeed of the family-planning programme, it was accepted that without comprehensive health care with universal coverage, and without linking health to overall development, health improvement was bound to be chimerical. International agencies accepted the need for integrated programmes along with the satisfaction of the minimum needs of the population in order to meet demographic goals. One reason, of course, for the appeal of vertical programmes was that many of these were donor-led and each donor wanted to see a programme of their funding on the ground. The second was related to a sense of technical hubris: programmes were initiated around technologies without a clear idea of how diseases were interlinked and in turn linked to an environment. It was further assumed that there was no other alternative to such programmes, especially in the short run, in other words, that they were cost-effective given financial constraints. All these ideas and arguments now ran aground, but were to be resurrected again later.

Widespread international disillusionment with vertical programmes, the recognition of the need to provide sufficient coverage to rural populations, and the faltering integration of preventive and promotive programmes together contributed to the World Health Organisation (WHO)-United Nations International Children's Emergency Fund (UNICEF) initiative towards the declaration of the goal of 'Health for All through Primary Health Care' at Alma Ata in 1978. Indeed, at this point, the WHO saw a 'major crisis on the point of developing' in both the developed and the developing world as a result of the 'wide and deep seated error in the way health services are provided' (Newell, 1978: 903).

As Hodgson noted:

> The failure of over a decade of family planning to substantially lower fertility in a number of societies had led to some questioning it as a method of population control. Still considering rapid population growth a serious problem, some of the disenchanted argued for more coercive forms of population control, while others called for redirecting development benefits to the impoverished to hasten their adoption of the small family ideals. (Hodgson, 1988: 557)

The World Bank and the Population Council endorsed this 'developmentalist' perspective. The echoes of such shifts were increasingly heard in the country. At the World Population Conference in Bucharest in 1974, the Indian Minister of Health and Family Planning stated that 'development is the best contraceptive'. Reflecting this new perspective, he observed:

> We are quite clear that fertility levels can be effectively lowered only if family planning becomes an integral part of a broader strategy to deal with the problems of poverty and underdevelopment .... Population policy is thus one of the several vital instruments for securing comprehensive social development, and it cannot be effective unless certain concomitant economic policies and social programmes succeed in changing the basic determinants of fertility. (Singh, 1974: 1)

This changed perspective found some resonance in the Fifth Five-Year Plan announced soon after.

THE FIFTH FIVE-YEAR PLAN (1975–80)

The Fifth Five-Year Plan noted:

> ... the bulk of our population lives in rural areas where health care services are extremely inadequate. Forty per cent of our population live below the poverty level and must be provided an access to minimal social consumption and investment .... The primary objective during the Fifth Plan is to provide minimum public health facilities integrated with family planning and nutrition for vulnerable groups—children, pregnant women and lactating mothers. (GOI, 1974: 241)

Accent was placed on the Minimum Needs Programme which was to 'receive the highest priority' and would 'be the first charge on the developmental outlays under the health sector' (ibid.: 234).

The Fifth Plan noted the inability to obtain the reduction in birth rate targeted in the Fourth Plan and aimed at the reduction of the birth rate by a more realistic five points by the end of the Fifth Plan period, that is, to a level of 30 per 1,000 population. To this end, 'the programme for family welfare planning' was to 'continue to be

accorded the same high priority in the Fifth Plan as it occupied in the Fourth' (GOI, 1974: 240).

The strategy adopted was to 'increasingly integrate family planning services with those of health, MCH and nutrition'. This was in line with the recommendations of the Kartar Singh Committee. The idea was to convert the vertical programme workers into multi-purpose workers, but they would be enjoined to pay special attention to family planning. It must, however, be noted that the integration was only envisaged for the field level while separate allocations continued to be the norm. In a sense it would not be too far-fetched to suggest that the entire public health system was to be suborned for the purposes of family planning.

The Fifth Plan, in addition to laying targets for physical infrastructure, laid down a target of 18 million sterilisations, 5.9 million IUCD insertions, and 8.8 million conventional contraceptive users. In order to implement the programme 'as a truly family welfare programme' it was envisaged that the extension of the scope and coverage of immunisation and nutritional prophylaxis would reduce the infant mortality rate and improve the nutritional status of children in the 0–6 year age group.

The outlay for family planning was increased to Rs 5.16 billion, health obtained an outlay of Rs 7.97 billion out of a total Plan allocation of Rs 537.5 billion, representing 0.96 and 1.49 per cent of the total outlay respectively. The Plan committed itself to improving health care services in rural areas under the Minimum Needs Programme.

The widespread political disillusionment of the time partially crystallising around a charismatic figure in the opposition, Jayaprakash Narayan, the judiciary striking down the election of the prime minister, and Jayaprakash Narayan's call to the police and the army not to obey orders led to the proclamation of Emergency in 1975. This meant that all normal democratic processes and laws were suspended and thousands of opposition leaders and activists were jailed. The Emergency facilitated the passage of the National Population Policy of April 1975. Among other reasons such as the down-turn in family-planning programme performance, the strengthening of the view that development was being thwarted by population growth, which therefore called for more decisive steps, the suspension of normal political processes and civil liberties, and the muzzling of the press, made

acceptance of this policy possible. It is, however, equally true that influential policymakers, and indeed the middle classes in general, tacitly, if not openly, supported these measures, much as they welcomed the Emergency itself, in the interests of law and order and efficiency.[5]

The policy document (Singh, 1976) acknowledged that 'our real enemy is poverty', but went on to add that

> Nonetheless it is clear that simply to wait for education and economic development to bring about a drop in fertility is not a solution. The time factor is so pressing and the population growth so formidable, that we have to get out of the vicious circle (sic) through a direct assault upon this problem as a national commitment. (ibid.: 1)

The policy announced contained a comprehensive range of anti-natalist measures. Representation in Parliament was frozen on the basis of the 1971 Census so that states that did 'poorly' in family planning did not gain any more representation than that which they already had. This was, of course, a blow to the concept of democracy but did not meet with any opposition. Further, allocation of resources to the states was to be on the basis of the 1971 Census figures and not on the basis of current population. This meant, of course, that states that had not performed well in family planning, largely the poorer states with poor health infrastructure, were to be punished. Family-planning performance became one of the criteria for financial allocations; 8 per cent of central aid to states was linked to their performance in family planning.

The policy statement stressed the importance of female education, nutrition, and basic health services. It reiterated the commitment made in the Fifth Plan to reach a birth rate of 25 per 1,000 by 1984 at the end of the Sixth Plan period. The measures specified to achieve this included raising the legal minimum age at marriage to 18 and 21 respectively for females and males, increased monetary incentives for sterilisation, offering 'group incentives' at the level of the village and district, introducing 'population values' in the educational system, drawing all government departments into the 'motivation of citizens to adopt responsible reproductive behaviour', and involving teachers, labour in the organised sector, voluntary agencies, youth and women's organisations in the family-planning movement. A new multi-media motivational strategy, directed specially at rural areas, was also unveiled. Special measures were proposed to raise female education levels and

organise child nutrition in an attempt to stimulate demand for family planning (Gulhati, 1974).

In addition, citing absolutely no evidence, the policy statement asserted that 'public opinion is now ready to accept much more stringent measures for family planning than before' (Singh, 1974: 4). It ruled out nation-wide compulsory sterilisation 'at least for the time being', but only because medical and administrative measures were inadequate for this purpose. However, state governments were permitted to do so if they felt 'that the time was 'ripe'. State governments were also permitted to introduce rules making employee benefits conditional on sterilisation after two children. Employees of the Union Government, it stated, were 'expected to adopt the small family norm' and 'necessary changes' would be made in their service conduct rules to ensure this.

Family planning was included in the Twenty Point Programme devised by Prime Minister Indira Gandhi and the Five Point Programme of her son, and heir apparent, Sanjay Gandhi. It has been noted that:

> For the first time senior politicians went out of their way in speeches on major public occasions to express the Government's commitment to birth control; previously such speeches had been rather rare and, when they happened at all, had usually been confined specifically to family planning events. (Cassen, 1978: 183)

In other words, political backing at the highest level was forthcoming for the adoption of a policy which implicitly compromised citizenship with fertility, which advocated compulsory sterilisation and the use of administrative machinery to achieve what had hitherto been thought of as 'unthinkable' (Minkler, 1977b).

The Minister of Health and Family Welfare, Karan Singh, wrote to the prime minister that 'the problem is now so serious that there seems to be no alternative but to think in terms of introduction of some element of compulsion in the larger national interest' (GOI, 1978a). Prime Minister Indira Gandhi on her part, addressing the Joint Conference of the Association of Physicians in India in January 1976 stated:

> We must now act decisively and bring down the birth rate. We should not hesitate to take steps which might be described as drastic. Some personal rights have to be held in abeyance for the human rights of the nation: the right to live, the right to progress. (cited in ibid.: 120)

It is thus not surprising then that sterilisations were performed with new zeal in this atmosphere. Targets for sterilisation were set at various administrative levels, most importantly at the level of the district, where the Collector was charged with pursuing the new family-planning goals.

The states, for their part, vied with each other to achieve the targets set. Indeed, these targets were raised to higher levels by a number of state governments when chief ministers sought to ingratiate themselves with the powers that be at the Centre. Bihar, for instance, doubled its target from 0.3 to 0.6 million as did Maharashtra, from 0.562 to 1.2 million; Madhya Pradesh and Himachal Pradesh tripled their targets. Still others, more enthusiastic, quadrupled it: Uttar Pradesh, from 0.4 to 1.5 million and West Bengal from 0.392 to 1.1 million. Punjab increased its target by up to five times (GOI, 1978a).

The original targets of 4 million sterilisations for 1976–77 was ostensibly reached by September 1976, although the numbers reported and their demographic import have been questioned. Indeed, the Joint Secretary in the Ministry of Health wrote to the Chief Secretaries of states that: 'It might not be much of an exaggeration to say that 1976 was the year of family planning in India' (GOI, 1978a: 120).

The December 1976 issue of *Centre Calling* a Ministry of Health publication, noted:

> Never in the history of the family planning programme have the States achieved the national sterilisation targets manifold. It ranges from 400 per cent to more than 100 per cent in an overwhelming majority of the States and that too in eight months. (cited in Cassen, 1978: 120)

A host of incentives and harsh disincentives were declared by the states: the requirement of a sterilisation certificate before grant of government permits, rural credit, and even fertilisers; denial of school admission to children of parents with more than three offsprings; offering re-housing after slum clearance only to those who accepted sterilisation;[6] and so on. In some places, police detachments were employed to obtain motivated clients for sterilisation (GOI, 1978a).

Maharashtra passed the Maharashtra Family (Restriction on Size) Bill, 1976. The title first given to the Bill was more forthright: it was called the Maharashtra Compulsory Sterilisation Bill. As the title indicates, the Bill made sterilisation compulsory after three children. It was Maharashtra that had in the meeting of the National Family-Planning

Council in 1975 first suggested compulsory sterilisation. Indeed one of its most prominent advocates was Dr Pai who described women as 'baby factories' (Cassen, 1978: 189). There was surprisingly little public resistance although that later convert to Hindutva, the Shankaracharya of Puri, announced the formation of an All-India anti-Family Planning Action Committee to start an agitation against the 'genocide of Hindus' (ibid.: 361).

The Maharashtra Bill was passed to the centre for ratification and awaited the President's assent. Other states, namely, Punjab, Haryana, and Uttar Pradesh, followed Maharashtra's example, but awaited the outcome there. However, before this could happen, the government at the centre was voted out of power.

The fear and resistance these moves evoked soon surfaced. In many rural areas of Haryana, Rajasthan, and Uttar Pradesh, there were reports of people attacking or fleeing from official vehicles that were suspected to be involved in the family-planning campaign. At other places, people avoided health centres for fear of being nabbed for sterilisation. At still other places, people refused vaccination fearing it was for purposes of sterilisation. Bose notes that those forced to undergo sterilisations included bachelors, persons with no children, old persons, patients in hospitals, inmates of jails and night shelters, and pavement dwellers (Bose, 1988: 55). There were also riots resulting in police firings and deaths, for example, during the well known Turkman Gate episode in 1976. Towards the end of 1976, there was a major riot in Muzaffarnagar in Uttar Pradesh; the foreign press estimated between 50 and 150 deaths due to police firings during this riot. These reports were, of course, underplayed. The Prime Minister in a statement in the Parliament is reported to have admitted that there had been 'some' deaths, but claimed that 'some people who had nothing to do with family planning had been killed by violent groups' (Cassen, 1978: 362). Sterilisation itself took a ghastly toll: 1,774 deaths were reported (GOI, 1978a: 230).

This is undoubtedly the largest ever loss of lives in the history of a 'welfare' programme. Indeed, it would not be exaggeration to state that the scars of the family-planning programme of the Emergency period still rankle as they gave a bludgeon blow to the credibility of the health care system.

Bose estimates that what he calls the 'Sanjay Effect'—a combination of 'coercion, cruelty, corruption and cooked figures' accounted for 7 million forced sterilisations (Bose, 1988: 52).

In the election of 1977, the Congress Party was swept out of power largely due to what came to be described as the 'excesses' committed in the name of family planning (Davidson, 1979). The new government also committed itself to checking population growth. In his address to the Parliament on 28 March 1977, the President stated:

> Family Planning will be pursued vigorously as a wholly voluntary programme and as an integral part of a comprehensive policy covering education, health, maternity and child care, women's rights and nutrition (GOI, 1978b: 3).

The Population Statement of the government averred that: 'family planning has to lifted from its old and narrow concept and given its proper place in the overall philosophy of welfare' (GOI, 1977: 36). Towards this end, the Statement highlighted the need for the extension of rural health care, female literacy, and legislation for raising the legal minimum age at marriage for females to 18 and for males to 21. The Statement also emphasised the need for special attention to be given to research in the field of reproductive biology.

The Statement asserted that the family welfare programme 'embraces all the principal areas of human welfare'. To symbolise the shift of focus, the programme and the executive department concerned were rechristened the family welfare programme and department respectively. The word 'target' was replaced by the phrase 'expectation of achievement'.

In view of the sharp fall in family-planning programme performance that ensued, the government announced 'an entirely new scheme' for strengthening rural health care services. Supposedly modelled on the Chinese 'barefoot doctors' scheme, the Community Health Volunteers Scheme launched in 1977, as a step towards repositing 'people's health in people's hands', was simultaneously visualised as a scheme for tackling the problem of population 'on a war footing' (GOI, 1975b: 8).

The Draft Five-Year Plan, 1978–83 noted that

> The climate of coercion and pressure as was witnessed in some parts of the country during the period of internal emergency in connection with the implementation of the Family Welfare programme resulted in an attitude of antipathy and indifference towards this programme in the post-Emergency period (GOI, 1978c: 235).

It thus committed itself to continue giving a high priority to the programme. Allocations of Rs 7.65 billion to family planning and Rs 13.3 billion to health were made out of a total outlay of Rs 1162.4 billion, representing 0.6 and 1.1 per cent of the budget respectively. These figures, however, belie the priority said to have been afforded to both health and family planning in the period. The Plan proposed the establishment of a Working Group on Population Dynamics to study the demographic situation and to make recommendations for the future.

The Working Group on Population Policy that was established by the Planning Commission, asserted in its Report that 'population policy and general development strategy are two sides of the same coin' (GOI, 1980a: 1). Yet they unoriginally viewed the issue in terms of creating the necessary level of demand while maintaining supply of services. There were nevertheless several important features to the report of the Working Group. They disaggregated the states of the country into three groups with different levels of demographic, health, and social development, suggesting different policy and programme packages for each of them. They emphasised the crucial role of 'population-influencing policies' such as improved health, water supply, nutrition, education and employment, and the role and status of women. Further, they argued that decentralised planning of local needs should be the basis of health and family-planning plans. They strongly argued the case for a voluntary programme emphasising that socio-economic development needed to be focused on. Arguing that there was no evidence of a crude birth rate (CBR) below 20 per 1,000 being possible in a population that was economically and socially backward, they highlighted the importance of strengthening rural health care. Nevertheless, the goals were set in demographic terms: the Group recommended the long-term demographic goal of a net reproductive rate of one for the whole country by 2001.[7] Further, the Group recommended, citing no evidence, that 'since women are the best votaries of the programme', the programme 'for the immediate future be increasingly centred around women' (ibid.: 36).

Thus the programme henceforth came to be centred on women, since it was now abundantly clear that a programme focused on sterilising men was politically costly. In India's culture of course, women were expected to silently contribute to their family's welfare. It was on this fact—and not on the need to increase the rights of women—that

the programme now hinged itself, exploiting the weak and the defenceless. Patriarchy, intersecting with class, takes many variegated forms indeed, and this was one of them.

Inspired in part by the Alma Ata Declaration of 1978, there was another influential policy document of the period. This was the Report of the ICMR–ICSSR (Indian Council of Social Science Research) Committee, a scathing indictment of health sector development in the country (ICMR–ICSSR, 1980). Noting that while there had been important health achievements, 'our failures are greater still' (ibid.: 5). The Committee observed that health had not been integrated with overall development and thus that the family-planning programme was far from being a success. Noting that the greatest weakness of Indian society was not just poverty but inequality, they highlighted how this had differential health and demographic consequences for different sections of the population. Their most important recommendation was that 'the existing exotic, top-down, elite-oriented, urban-biased, centralised and bureaucratic system which over-emphasises curative aspects, large urban hospitals, doctors and drugs should be replaced by an alternate model' (ibid.: viii). Urging that health expenditures needed to be placed at least at 6 per cent of the gross domestic product (GDP), if there was commitment to changing the utterly unacceptable health scenario, they outlined a series of policy measures towards an alternative.

Where population was concerned they emphasised food, employment, income, and equity, especially gender equity. They noted that there continued to be economic and social incentives for large families in certain sections of the population and that the given levels of child survival did not inspire confidence in the programme. At the level of the programme, itself, however, they offered no new directions. With one exception: that along with targets for family planning, there should be targets for health achievements.

In sum, the Fifth Plan period witnessed the failure of yet another approach to population control, that of coercion. We see the same shifts of programme strategy and emphasis that were also noted in the earlier Plan periods. And yet the goals remained largely elusive. Indeed towards the end of this period, it was acknowledged that the programme had received a setback (GOI, 1980b). The Fifth Plan objective of reducing the birth rate from 35 per 1,000 to 30 per 1,000 by 1978–79 could not be achieved; in fact, the level of effective family-planning protection came down from 23.9 per cent in

1976–77 to 22.5 per cent in March 1980 by the government's own admission (GOI, 1980b).

THE SIXTH FIVE-YEAR PLAN (1980—85)

Despite accepting the recommendations of the Working Group on Population Policy and being influenced by the ICMR–ICSSR Report, the Sixth Plan did not reflect the fundamental thrust of these policy documents. Noting the 'reverses' suffered by the programme, the Sixth Five-Year Plan document, set out 'to arrest the trend'. It observed:

> It is almost axiomatic that economic development can in the long run bring about a fall in fertility rates. However, developing countries with large populations cannot afford to wait for development to bring about a change in the attitude of couples to limit the size of their families as the process of development itself is stifled by population growth. Limiting the growth of population is therefore one of the main objectives of the Sixth Plan. (GOI, 1980b: 375)

Basing itself partly on the recommendations of the Working Group on Population Policy, the Plan adopted the long-term demographic goal of reducing the net reproduction rate to one by 1996 for the country as a whole, and by 2001 in all the states. The targets set for the Plan included 22 million sterilisations, 7.9 million IUCD insertions, and a couple protection rate of 36.56 per cent. The strategy adopted emphasised 'an integrated approach to the problems of public health and proper coordination of activities of different departments having a bearing on family planning such as maternal and child care'. (ibid.)

The Plan noted that 'the family planning programme has to be made part of the national effort for providing a better life to the people' and drew attention to the Plan's anti-poverty programmes and programmes for literacy, especially female literacy, and nutrition programmes in this regard. It is thus that female literacy assumed an importance for utilitarian reasons, not as a matter of rights and gender justice.

The Plan also acknowledged that 'high morbidity and mortality rates' were 'responsible for the desire for more children'. The aim

was, therefore, 'to bring down these rates through improvement of health and nutrition status through various extension programmes of immunisation, prophylaxis, supplementary nutrition and health care services'.

The outlay on family planning was again increased and amounted to Rs 10.1 billion while health obtained Rs 18.2 billion out of a total Plan outlay of Rs 975.5 billion, representing 1.03 and 1.80 per cent of the total outlay respectively. The strengthening of rural health services was undertaken under the Minimum Needs Programme (MNP) the share of MNP in the health budget rose from 17 per cent in the Fifth Plan to 31 per cent in the Sixth plan. However, this effort at creating health infrastructure was at the cost of preventive programmes: the reduction of medical infrastructure was only 4 per cent, whereas that or the control of communicable diseases was 11 per cent (Qadeer, 1985).

In 1983, the government announced the first health policy since Independence. The National Health Policy, after noting the advances in health since Independence, observed that

> ... demographic and health picture still constitutes a cause for serious and urgent concerns. The high rate of population growth continues to have an adverse effect on the health of our people and quality of their lives. The mortality rates for women and children are still distressingly high; almost one third of the total deaths occur among children below the age of five years; infant mortality is around 129 per thousand. Efforts at raising the nutritional levels of our people have still to bear fruit and the extent and severity of malnutrition continues to be exceptionally high. Communicable and non-communicable diseases have still to be brought under effective control. The high incidence of diarrhoeal diseases and other preventive and infectious diseases, specially among infants and children, lack of safe drinking water and poor environmental sanitation, poverty and ignorance are among the major contributory causes of the high incidence of diseases and mortality. (GOI, 1983: 2)

It is obvious that a system that announces a health policy 35 years after Independence could not have placed much emphasis on the health of the population. Nevertheless what was so striking about this policy statement was the ease with which the population itself was blamed for the poor state of health in a classic case of victim-blaming. The first fault of the people was, of course, their reproductive excesses. As if that were not enough, they are also blamed for poverty and ignorance. Not at fault was the abysmally low allocations made to

health, the fact that of this low allocation, a large proportion was towards medical colleges and hospitals, that of the remaining funds for public health, the malaria eradication programme cornered a large proportion so that there were actually no funds left for the primary health care system.

But the Alma Ata and the ICMR–ICSSR document did leave their imprint, for the policy went on to observe

> The existing situation has been largely engendered by the almost wholesale adoption of health manpower development policies and the establishment of curative centres based on the Western model which are inappropriate and irrelevant to the health needs of our people and the socio-economic conditions obtaining in our country. The hospital-based disease and cure-oriented approach towards the establishment of medical services has provided benefits to the upper crusts of society, specially those residing in urban areas. The proliferation of this approach has been at the cost of providing comprehensive primary health care services to the entire population ... and the neglect of the preventive and promotive public health. (GOI, 1983: 3)

While committing itself to the goal of health for all by 2000 through the primary health care system, the policy went on to argue that 'irrespective of changes, no matter how fundamental, that may be brought about in the overall approach to health care and the restructuring of the health care services, not much headway is likely to be achieved in improving the health status of the people unless success is achieved in securing the small family norm and moving towards the goal of population stabilisation' (ibid.: 4). Thus, the cart of population control was placed before the horse of health care for the people. Further, the policy argued that 'with a view to reducing governmental expenditure ... programmes may be devised to encourage the practice by private medical professionals and increased investment by non-governmental agencies by offering organised logistical, financial and technical support' (ibid.: 7). In addition, the policy stated that 'to establish super-speciality services and to reduce governmental expenditures, planned efforts must be made to encourage private investments in such fields' (ibid.: 8).

Thus, the fact that India had one of the largest, most unregulated, private health care system in the world was forgotten as it was decided, by a government pleading paucity of funds, that further subsidies be provided to the private sector in health care. One important turn in

health sector development in this period was the official impetus provided to the growth of the private and the NGO sector in the country. It was increasingly becoming evident that by the mid-1980s both the rural and urban middle classes increasingly utilised private health care services (Baru, 1998). These groups who had benefited, indeed been created by state-led growth of the Nehruvian years, increasingly looked askance at state intervention in the economy, or indeed any other sector. They also increasingly sought access to consumer goods and durables that were available in the West. They had, of course, no time for concepts such as import-substituting growth or indeed even equity with growth. They were prepared to kick the very ladder that had helped them climb socially and economically. But the increasing visibility of these groups, their disproportionate influence on policy, also saw for the first time a range of subsidies being provided for the growth a 'new' private sector in the country.

During the Sixth Plan, there was, in line with the recommendations of the Working Group on Population Policy, an increasing emphasis on the sterilisation of women. This was partly on account of the realisation that focusing on men had proven politically expensive, and indeed unsustainable. In this situation, to take advantage of the patriarchal victimisation of Indian women seemed natural, especially as the Working Group had affirmed that 'women are the best votaries' of family planning. It was partly also related to the fact during the UN's International Decade for Women, questions related to the role of women in development increasingly adumbrated across the globe. Had development in the post-War years by-passed women? Had policies across countries, considered gender-neutral, in fact contributed to the marginalisation of increasing numbers of women. Indeed was it possible at all to consider policies as being either gender neutral or class neutral? How then were policies to bring women centre stage in development discourse to be initiated? As what has been commonly referred to as the second crest of the women's movement developed, such questions could no longer be avoided. As we shall see in Chapter 4, this new awareness of women in development was to be a double-edged sword, not always to the betterment of women.

In terms of operational strategy, what resulted was a focus on female sterilisation, often in camps. At the same time, the availability of the laparascope made it possible to carry out sterilisations in record time, in operations described as 'something like a war'.[8] This same militaristic fervour led, during this period, to the launch of trials

with more lethal weapons: injectables (Net En and Depo), implants (Norplant), and indeed a vaccine.

In 1983, the ICMR in a press release announced its intention to introduce the injectable Net En in the family-planning programme. Information about the trials initiated was not forthcoming to women's groups and health groups who sought them, aware of the serious controversies that surrounded both injectables and implants in the West. Net En, for instance, had been withdrawn from the market when it was discovered to be mutagenic—and potentially carcinogenic—in animals.

It was well known that the authorities in the USA and the UK were under tremendous pressure both from the manufacturers of these drugs and the international population control establishment to license them for use. This would enable the use of these contraceptives in the Third World, circumventing the accusation that they were being promoted in other countries while, in the case of Depo, banned in the USA, the country of manufacture. Public hearings had been held in the USA and UK where women's groups had presented evidence on both the health hazards associated with these drugs and the potential for abuse.

In 1986 in a PHC called Patancheru in Andhra Pradesh a camp was organised to initiate Phase IV trials with Net En under the aegis of the Osmania Medical College. Members of a Hyderabad-based women's organisation discovered that the potential recruits to the trials were not informed that they were participants in a trial: all they knew was that they were to receive injections to prevent pregnancy. In a similar case, in Jaipur, the Sawai Man Singh Medical College issued posters advertising injectables in a similar manner. Three women's oganisations—Stree Shakti Sanghtana, Saheli, and Chingari—filed a writ petition in the Supreme Court asking for a stay order (Saheli, 1999). Not only were these trails violating minimum norms of informed consent—a violation of the Helsinki Declaration of medical ethics—there were also serious questions about the suitability of these contraceptives given the health and socio-economic situation of women in the country. Perhaps more important, given what we know about the family-planning programme in the country and the methods used in the trial, there were real dangers of misuse in order to meet demographic goals. The stay was not granted, but in a partial victory to the health groups, approval was granted in 1986 only for private marketing.

At the same time trials with the implant Norplant commenced in 1984, but were abandoned after two years when the manufacturer stopped making the particular model in view of fears of carcinogenicity (Agnihotri Gupta, 2000). The Population Council reformulated Norplant and the new avatar Norplant (R) has been widely tested and used. Developed by the Population Council, it is manufactured by a Finnish company. Norplant is used in 26 countries, and is typically purchased by these countries with loans provided by the World Bank and USAID. The documentation of the abuse of Norplant is vast, being used, for example, in what are called 'safaris' in Indonesia. In India, Norplant has largely been promoted by NGOs, which have attempted to have the method introduced into the official programme.

The ICMR carried out a study on 1,466 women with Norplant. As many as 58 per cent discontinued use in less than five years, citing menstrual problems. Other major problems reported included deep vein thrombosis—a potentially fatal condition—hepatitis, arthritis, and dimness of vision—associated with Norplant use throughout the world (ibid.). A small study conducted by the Forum for Women's Health in Mumbai and Baroda revealed that many women who had received the Norplant implant had not been informed that they were part of a trial. Neither had they been told of the potential side effects. What is more shocking is that in Baroda, Muslim women had been specifically targeted for these trials (cited in ibid.).

During 1976–78, clinical trials with an anti-hCG (Human Chorionic Gonadotropin) vaccine were carried out on 63 women in India, Finland, Sweden, Chile, and Brazil. The trial with an antifertility vaccine, developed by G.P. Talwar of the National Institute of Immunology, New Delhi, was abandoned due to low response and the wide variations in antibodies among the trial subjects (Saheli, 1998). Consequently, a modified vaccine went into clinical trails under the supervision of the ICMR at five centres in Delhi, Mumbai, and Chandigarh. Given the problems that emerged, Talwar was to conclude that the vaccine at present was not ready for adoption in the family-planning programme. The search for an effective vaccine, however continues.

Again, as happened so often in the past, what was current in technology was expected to perform extraordinary wonders; and again, as in the past, with mounting disappointment.

THE SEVENTH FIVE-YEAR PLAN (1985–90)

Reviewing the progress of the family-planning programme in the preceding Plan period, the Seventh Plan document observed that achievement fell short of targets in all components of the programme (GOI, 1985). It was noted that here had been an inability to meet targets both in infrastructure development and in the control of communicable diseases. And further, that the performance of the MCH component of the programme, in immunisation and antenatal care was 'far from satisfactory' (ibid.: 271). The shortfalls were attributed to, among other factors, lack of infrastructural facilities, the persistently high infant mortality rates and high levels of maternal and child mortality.

While the infant mortality rate had indeed declined, the levels, at 114 per 1,000, as the Plan acknowledged, was still 'staggeringly high' (ibid.: 274). Indeed it was high enough not to inspire confidence in child survival.

In view of the actual performance in the Sixth Plan period, the goal of reaching a net reproductive rate of one was pushed forward from 2006 to 2011. The Seventh Plan set forth the following targets to be reached by 1990:

(*a*) an effective couple protection rate (CPR) of 42 per cent;
(*b*) a crude birth rate (CBR) of 29.1,
(*c*) a crude death rate (CDR) of 10.4,
(*d*) an infant mortality rate of 90 per 1,000 live births,
(*e*) universal immunisation of children, and
(*f*) antenatal care for 75 per cent of all pregnant women.

To reach the target of 42 per cent CPR, the Plan stipulated the following targets: 31 million sterilisations, 21.25 million IUCD insertions, and during the terminal year, 14.5 million users of conventional contraceptives. In addition to recommending the strengthening of the health infrastructure and the vigorous implementation of the family-planning programme with particular reference to the poorly performing northern Indian states, the Plan emphasised the need to pay greater attention to MCH activities to enhance child survival. The allocation to family planning was again increased, to be almost on par with that of health, a case of the tail wagging the dog.

Family planning and health obtained an outlay of Rs 32.56 billion and Rs 33.92 billion respectively out of a total outlay of Rs 1800 billion, representing 1.80 and 1.88 per cent of the budget respectively.

The year 1986 witnessed the enunciation of a new population policy. The National Population Policy of 1986 asserted that family planning

> ... is one of the essential components of the national strategy for growth which places equal emphasis on accelerated development and recognises the fact that the process of development is apt to be lopsided unless socio-economic imbalances among the people, including the imbalances in the health services, are speedily removed. It looks at birth control not as an end in itself but as vital means to the attainment of Health for All in the shortest possible time. (GOI, 1986: 1)

The policy statement enunciates the government's commitment to promote a voluntary, two-child norm. To this end, the policy committed itself to bring down morbidity and mortality rates, in particular early childhood mortality, through strengthened health services, enforcement of the law relating to age at marriage, health and population education, educational and employment facilities for women and so on. Incentives, and the policy of linking central assistance to states, were to be continued.

Over the period of the Seventh Plan the programme was pursued with renewed vigour, concentrating on one of the most vulnerable sections of India's population—poor women. As Bose observed, the family welfare programme was

> perceived as the family planning programme, which in effect is the same as the sterilisation programme, which in turn means the female sterilisation programme, which basically means the laparascopic method of sterilisation. (Bose, 1989: 3)

The bureaucratic chain from the Centre to the village level was activated to obtain cases for sterilisation (Banerji, 1988). One must keep in mind that this long chain of coercion begins in the international centres of power and wealth. Achievement of targets in family planning became an index in the assessment of bureaucrats. The Government of Maharashtra, known for its aggressive pursuit of family planning targets, rewarded the best achievers among collectors with rest and recreation holidays in Bangkok, in a macabre replay of Vietnam body counts.

All these steps notwithstanding, the mid-term appraisal of the Plan noted that

> ... a recent report of the Registrar General based on SRS data indicates that the birth rate has not fallen. This is in spite of the fact that couple protection rate has gone up considerably during the period. On the contrary, birth rates have shown a rising tendency in some states. The data on age specific fertility rate by SRS also corroborate this fact .... The discrepancy between the projection and what has been observed arises mainly because the linkage between the CPR and the fertility rate is more complex than we assumed. (GOI, n.d.: 194)

The mid-term appraisal also acknowledged that of the total decline in the birth rate during the period 1961–81, 47 per cent of the reduction could be attributed to a rise in the age at marriage, a change in the age structure of the population, and other factors. That is to say, factors other than those related to the family-planning programme contributed to a substantially large proportion of the decline in the birth rate over this period. The document concluded that 'fertility behaviour depends on much more than access to family planning services' (ibid.: 196).

The lack of correlation between the CPR and the birth rate was also commented extensively upon by Bose. He noted the paradoxically high CBR of 28.7 in Punjab, with a CPR of 62.4; and a CBR of 21.3 with a CPR of 44.6 in Kerala. Haryana offered another example of a state with a high CPR (53.2) and a high CBR (28.7) (Bose, 1989).

The GOI had to belatedly acknowledge that the programme had reached a dead end. The Public Accounts Committee in its 139th Report observed that despite massive financial inputs into the programme, the birth rate had remained stationary around 33 per 1,000 since 1977 (*EPW*, 1989: 704). In his inaugural address to the Eleventh International Population Congress in September 1989, Prime Minister Rajiv Gandhi observed that there was 'inadequate causal connection between our family planning programme and the impact of these on our birth rates' and that 'the rate of increase in financial outlays on family planning is not matched by a commensurate decline in birth rates' (GOI, 1989: 100).

During this period, acquired immune deficiency syndrome (AIDS) control began to assume increasing importance. This was not

so much because it was assessed as a major public health problem epidemiologically, but because funds began flowing in, albeit as loans, from international agencies (Rao, 1998). The National AIDS Control Programme commenced with a soft loan of US $84 million from the World Bank and technical assistance from the WHO. The looming threat posed by AIDS was one factor to mould the approach in the future. But international agencies also set the agenda in the tuberculosis programme, a programme with a difference. The National Tuberculosis Programme (NTP) was unique in that it was not a vertical programme and that it was the only programme initiated in the country on a sound epidemiological basis, indeed it had also been cast upon extensive social science studies. In a memorable phrase, it had been designed to sink or sail with the general health services. The NTP had sunk because the preoccupation with malaria and family planning meant that the general health services were not permitted to stay afloat. The reorganisation now initiated by donors was partly related to the association of this disease with AIDS. It was also dictated by the increasing incidence of drug resistance. Above all, it was dictated by the availability of expensive second-line drugs, not manufactured in the country, but made available against loans. This was not based on epidemiological studies assessed as cost-effective, nor likely to be one that our country could afford. This was, once again, an approach based on medical technology.

Towards the end of the Seventh Plan, as indeed in the past at the end of the Third and Fourth Plans, it was increasingly, grudgingly, accepted that the family planning programme had not succeeded. Was there to be a way out of the impasse? There seemed to be no new technical breakthrough in the offing: the research on the anti-fertility vaccines, which had promised just such a breakthrough, had led up a blind alley: there were far too many technical problems, seemingly insurmountable. Injectables and implants were expensive, needed to be imported, and were mired in controversy. A way out of the impasse was to be provided by a 'paradigm shift' that was heralded in Cairo in 1994, which we shall consider Chapter 4. But there were winds of change that were blowing in the larger economy that were to have profound consequences to health and family planning, indeed to the way India had been imagined. A new direction was given to the India economy, in the 1990s with the initiation of the Stabilisation-Structural Adjustment Programme under the aegis of the World Bank.

THE EIGHTH FIVE-YEAR PLAN (1992–97)

The political turmoil unleashed by right-wing forces making a determined bid for power, the nation-wide movement undertaken towards the demolition of the Babri Masjid in Ayodhya around which this mobilisation was built, and the violence and bloodshed this unleashed resulted in a great deal of instability in the Indian polity during this period. This was also reflected in the frequent change of government. As a result, annual Plans were implemented during the years 1990–92; the Eight Plan was thus officially launched only in 1992. Meanwhile, the world was turned upside down with the collapse of the Berlin Wall in 1989 and the collapse of the Soviet Union.

Towards the end of the 1980s, with a substantial middle class eager to dismantle the public sector and state-led growth that had ironically created this class, with a consensus among the elite to jettison the concerns of the poor and integrate with the global economy, the Indian government initiated measures that put paid to ideas of import substituting growth. Given its increasing current account deficit, initially the government relied on short-term commercial loans and volatile non-resident Indian (NRI) deposits. But external debts mounted enormously and the debt service burden accounted for 5 to 30 per cent of export earnings. At the same time there was a massive capital flight in expectation of the devaluation of the rupee in 1991. Between April and June 1991 there was a net outflow of $1 billion (Vanaik, 2001). In was at this point that the Indian government approached the World Bank and the International Monetary Fund (IMF) for a string-attached loan which had the familiar contours of the stabilisation-structural adjustment package, tried and tested in other countries.

The Prime Minister in his Foreword to the Eighth Plan wrote:

> The Eighth Plan is being launched at a time of momentous changes in the world and in India. The international political and economic order is being restructured everyday, and as the 20th century draws to a close, many of its distinguishing philosophies and features have also been swept away. In this changing turbulent world, our policies must also deal with changing realities. Our basic policies have stood us in very good stead, and now provide us an opportunity to respond with flexibility to the new situation. (GOI, 1992: 1)

I shall discuss the broad causes and the contours of the changes introduced under the aegis of international agencies in another chapter, including the consequences for health. The larger macro-economic changes were also reflected in the health and population policies of the times, with the agenda, as in the case of the economic policies, increasingly being set by the World Bank. One consequence of the global changes in the late 1970s and 1980s was the diminution in the role of the WHO in international health while the World Bank increasingly began setting the agenda, and also increasingly began funding health programmes.

The World Bank prescriptions for health, as indeed for the social sectors, were, in a nutshell, extremely simple. This was that the state must concentrate on overall economic growth through policies of liberalisation, globalisation, and privatisation. Within the health sector, the state must concentrate on a minimum clinical package, including family planning, while the private sector must be encouraged to play a larger role in the provision of curative care. These were part of a larger process of health sector reform that included cuts in public expenditure to compensate which it was felt necessary to raise resources through fee-for-services. While it is indeed true that the health sector had myriad, and seemingly insurmountable, problems, health sector reforms have typically thus focused on issues of financial efficiency rather than with questions of out-reach, overall effectiveness, equity, or long-term sustainability (Baru, 2002).

A complex number of reasons, again discussed in a later chapter, saw the coming together of a 'new alliance of Neo-Malthusians and feminists' (Hodgson and Watkins, 1997: 470) at the 1994 ICPD in Cairo. This new alliance, with the backing of institutions such as the World Bank and the Population Council, brought forth a 'paradigm shift' in the population programmes of developing countries. How these were translated into policies we shall see later in another chapter.

All these changes brought to the fore, in the health sector, not a commitment towards health for all, but 'health for the underprivileged' (GOI, 1992: 322). The Plan noted that the disease and death rates were still 'unacceptably high' and that the rural health services were 'still not fully operationalised'. But admitting that the backlog of infrastructure was 'staggering' and 'unachievable', the Plan decided on consolidation rather than expansion. While the Panchayati Raj system offered a new window of opportunity for the delivery of health care, rising costs and the inability of the government to meet them

meant that it was 'time that the concept of free medical care [was] reviewed and people are required to pay, even if partially, for services' (GOI, 1992: 323). At the same time, along with the 'new policy of the government to encourage private initiatives, private hospitals/clinics' were to be supported. (ibid.: 324)

The Plan noted that while the Seventh Plan objective of achieving a CPR of 42 per cent had been met, there had not been a matching decline in the birth rate. The Plan also noted that 'containment of population is not merely a function of couple protection or contraception, but is directly correlated with female literacy, age at marriage of girls, status of women in the community, the IMR, quality and outreach of health and family planning services and other socio-economic parameters' (ibid.: 333). Observing several significant shortfalls in provision of services, the Plan nevertheless noted:

> Containing population growth has been accepted by the Government as one of the six most important objectives of the Eighth Plan with the aim of reducing the birth rate from 29.9 per thousand in 1990 to 26 per thousand in 1997. The IMR will be brought down from 80 per thousand live births in 1990 to 70 by 1997. To give a major thrust in this priority area, which constitutes the pivotal point for the success of all developmental efforts, a National Population Policy needs to enunciated and adopted by the Parliament. (ibid.: 334)

It is sobering to recall that the Third Plan had set out to reach a CBR of 25 by the year 1973. Much water having flown under the bridge, yet it was envisaged that a figure slightly above this was to be the target for the year 1997.

In a welcome departure, for the first time, no centrally fixed targets were specified. This was not, of course, to mean that targets did not exist for the Plan noted: 'The targeted reduction in the birth rate will be the basis of designing, implementing and monitoring the programme against the current method of CPR. While broad guidelines may be prepared by the Centre, suitable parameters would be designed by the individual state for this purpose' (ibid.: 336). In other words, that the states would now set their own targets, while the Centre would maintain the need for the targeted reduction in the birth rate, clearly a case of having the cake and eating it too. The operational strategy was spelt as area-specific, micro-planning, 'linking population control with the programmes of female literacy,

women's empowerment, social security, access to health services and mother and child care' (GOI, 1992: 338). Health obtained an outlay of Rs 75.82 billion while the allocation for family planning was Rs 65 billion, representing 1.75 and 1.5 per cent of the total outlay respectively. The health outlay and family planning outlay thus declined from the allocations of 1.88 and 1.81 per cent respectively of the total outlay of the Seventh Plan. Central grants as a proportion of a state's total medical and public health expenditure fell more sharply. In the case of centrally-sponsored disease control programmes, the share of central grants declined from 41 per cent in 1984–85 to 29 per cent in 1988–89, and even more sharply to 18.5 per cent in 1992–93. It must, however, be borne in mind that given the devaluation of the rupee, the decline in health and family planning outlays was, in fact, much larger and real expenditure thus declined very sharply indeed. This was, of course, in line with the neo-liberal tenets of the day.

In 1994, India committed itself to the RCH approach at Cairo. But in preparation for the Cairo Conference the central government unveiled a Draft National Population Policy that raised a storm. Together with the Swaminathan Committee report, the World Bank also came out with a policy document that was to profoundly influence developments in the country. Shaping both of them were 'the two major global changes taking place in many countries of the world, as an aftermath of the collapse of the Soviet Union in the late eighties and its overall impact on the Indian polity. First, [was] the process of democratic decentralisation and second, the increasing role of the market and non-governmental forces' (Srinivasan, 1995: 60). We shall consider these policy shifts in a later chapter.

One positive outcome of the Cairo Conference was the removal, formally, of method-specific targets in April 1995 on an experimental basis from Kerala and Tamil Nadu and from 17 districts in other states. In April 1996, targets were removed from all over the country, although influential planners bemoaned that this had been done 'without a proper appraisal of how the target-free system worked in practice' (Visaria, 2002: 21). It must be remembered that health groups and women's groups that had been spearheading the call for revamping the family-planning programme had protested for more than a decade against the abuse ushered in by targets, but in vain. Yet, Cairo managed to accomplish this in a jiffy. The change of heart, as we shall see later, was restricted to merely a section of policymakers

at the Centre, converted by the paradigm shift. The states, more removed from donors, were profoundly sceptical and thus the target-free approach was more rhetorical than real.

Given the encouragement to the NGO and private sector, and given the 'anything goes' atmosphere of the day, it is not surprising that scandals erupted. From India becoming a donor of kidneys in the international organ trade, to the conduct of research banned in other countries, anything at all was possible. One such scandal that came to light related to the use of quinacrine for the illegal chemical sterilisation of women (Rao, 2001: 524). Quinacrine, a synthetic anti-malarial, was being used to sterilise women by a slew of NGOs and private practitioners all over the country. This was despite a halt called by the WHO on clinical trials with this drug given the fears of mutagenicity and carcinogenicity, among other problems. Indeed the ICMR had discontinued its trial given a high failure rate. Promoting this large-scale abuse of rights were two right-wing doctors, Dr Elton Kessel of the International Federation of Family Health (IFFH) and Dr Stephen Mumford of the Centre for Research on Population and Security (CRPS), NGOs in the USA. Afraid that population growth in Third World countries would pose the danger of uncontrollable immigration by coloured peoples, the two had been promoting this method in a number of Third World countries. The proponents of the method declare that more than 100,000 women have been sterilised with quinacrine (Saheli, 1997). The All India Democratic Women's Association (AIDWA) and the Centre of Social Medicine and Community Health approached the Supreme Court of India with a public interest litigation to stop the use of quinacrine. Although the Supreme Court did ban the import, distribution and use of quinacrine for sterilisation, reports indicate that doctors are continuing with the method, albeit on a low key.[9]

THE NINTH FIVE-YEAR PLAN (1997–2002)

Noting once again the inability to make a dent in the health scenario, the Ninth Plan document drew attention to the marked disparities in health between states, and the sub-optimal functioning of PHCs due to a number of factors, including lack of infrastructure, critical lack of manpower, of equipment and drugs and so on. The Plan was different

from earlier ones in that it was far more detailed. Yet it was clearly lacking epidemiological priorities when given the weaknesses identified in the PHC system it went on to say that the Plan priorities included providing funds to strengthen tertiary health care, levying user charges. This despite the fact that it noted that there was a need to assess 'the exemption from import duties ... given in the past to private and voluntary agencies' (GOI, 1997: 152). In addition to tuberculosis, leprosy, and AIDS, non-communicable diseases were also identified as priorities. The Plan also notes the surveys carried out by the National Sample Survey Organisation (NSSO) which had indicated that the high cost of medical care was one of the leading causes of indebtedness. The solution proposed was health insurance, which was not surprising given that the insurance market had recently been opened up to foreign companies. The outlay for health, at Rs 51.18 billion, was a significant decline from the outlay of Rs 75.82 billion in the Eighth Plan period, and representing 0.6 per cent of the total outlay.

The Plan stated that 'reduction in the population growth rate has been recognised as one of the priority objectives during the Ninth Plan period' (ibid.: 206). It nevertheless noted that:

> The current high population growth rate is due to (1) the large size of the population in the reproductive age group (estimated contribution 60 per cent); (2) higher fertility due to unmet need for contraception (estimated contribution 20 per cent); (3) high wanted fertility due to prevailing high IMR (estimated contribution about 20 per cent). (ibid.: 207)

The priorities in the Plan were stated to be to meet the felt needs for contraception, and to reduce the infant and maternal morbidity and mortality so that there was a reduction in the desired level of fertility. Among the operational thrusts mentioned, was increasing participation of the private and voluntary sectors. Family planning received an allocation of Rs 151.20 billion, a huge increase from the Eight Plan outlay of Rs 65 billion.

During this period, two important policy documents were announced, first, the National Population Policy, significantly announced before the second, the National Health Policy. We will consider the National Population Policy and the population policies of the various states in another chapter.

The National Health Policy, announced in 2002, was remarkable in many respects. It was much more detailed than the policy of 1983, with sections on the private sector, medical ethics, the impact of globalisation on health and so on. It bluntly accepted that 'there is no gainsaying the fact that the morbidity and mortality levels in the country are still unacceptably high ... an indication of the limited success of the public health system' (GOI, 2002: 3). It noted the prevalence of communicable diseases, of malaria, tuberculosis, AIDS and that common water-borne diseases continue to take their toll. It also noted that there was also an increase of mortality due to 'life-style diseases' and the continuing high prevalence of malnutrition. It noted that public health investment has been low and that as a percentage of the GDP, had declined from 1.3 per cent in 1990—the start of the Structural Adjustment Programme (SAP)—to 0.9 per cent in 1999. It noted too that merely 17 per cent of the aggregate health expenditure came from public expenditure while the huge proportion of 83 per cent was out-of-pocket spending, adding 'given this, it is no surprise that the reach and quality of public health services has been below the desirable standard' (ibid.: 5).

Indeed it observed that public spending accounted for 96.9 per cent of health expenditure in the UK and even in that favoured haven of the free market, the USA, 44.1 per cent. It admitted that vertical programmes had been costly and ineffective and indeed that 'it is a widespread perception that, over the last decade and a half, the rural health staff has become a vertical structure exclusively for the implementation of family welfare activities' (ibid.: 8).

And yet, given this, it merely suggested an increase of the health budget to 2 per cent of GDP by the year 2010. India, we must remember, allocated an inadequate 3 per cent in the First Plan! The disjunction between diagnosis and cure is also evident in the act that women's health is provided all of three sentences. With reference to population, it repeated the neo-Malthusian refrain that 'efforts made over the years for improving health standards have been neutralised by the rapid growth of population' (ibid.: 20) while asserting that the principal features of the policy were covered under the National Population Policy. But the fact that the policy stated that 'in the context of the very large number of poor in the country, it would be difficult to conceive of an exclusive Government mechanism to provide health services to this category' (ibid.: 32) and that 'in principle,

this Policy welcomes the participation of the private sector in all areas of health activities' while also 'encouraging the setting up of private insurance instruments' and strongly encourages a what could be called health tourism, with 'domestic health facilities in the secondary and tertiary sectors providing services on a payment basis to service seekers from oversees' (GOI, 2002: 36) and indeed that these, private, facilities will be encouraged, give credence to the criticism that the policy 'legitimises privatisation' (Jan Swasthya Abhiyan, 2001).

We thus find, at the end of the Ninth Plan, a virtual tug-of-war with regard to the population policy. While the Centre is, for now, committed to a target-free approach, the states, some of whom have inaugurated population policies of their own—significantly none of them with health policies—have continued to rely on targets and at the policy level, announced programmes replete with elements of coercion. At the same time, there are moves afoot at the Centre to bring in an explicit commitment to targets and indeed a compulsory two-child norm. With health services in shambles, there are also moves to bring in injectable contraceptives. In short, the pull of neo-Malthusian tides seems to be irresistible.

NOTES

1. Military metaphors, alas, do not remain confined to scholarly commentators: the Shrivastava Committee urged that the population problem had to be tackled 'on a war footing'. Recall too that the recipients of family welfare were referred to as targets.
2. A possibly apocryphal story is that foreign experts so keen to introduce the loop in India, were so convinced of the overwhelming, indeed paralysing, role of superstition in India, that they felt it would not be accepted if it was known by the name it was christened in the USA, namely IUD or intra uterine device. This was because IUD in medical jargon also stood for intra uterine death. Thus it was that the IUD was rechristened the IUCD for India's superstitious masses.
3. This again is unique to the family-planning programme. In a dextrous sleight of hand, incentives were referred to as 'compensation to the individual'. The issue, of course, is that if the programme was working for the welfare of the people was there a need for 'incentives'? Or was it meant to exploit the vulnerability of the poor? Giving 'incentives' to the staff led to widespread abuse, as documented for instance in Deepa Dharaj's powerful film on family planning, *Something Like a War*.

4. It is not entirely surprising that Mr Krishnakumar was subsequently referred to in Kerala as 'Vasectomy Krishnakumar'. Nor indeed that he was amply rewarded by the population establishment abroad.
5. The fact that the Emergency made trains run on time was much touted. It was conviniently forgotten that this was precisely the defense of Mussolini's fascism. Nor did people who should have known better ask themselves why you needed suspension of democracy to make trains run on time.
6. Thus certain colonies in east Delhi that came up during this period were referred to as *nasbandi* (vasectomy) colonies.
7. Feminist demographer, Professor Malini Karkal, observed in the 1980s that by focusing on the replacement of females, the group might provide an impetus to sex-selective abortion of females. Today this prescience seems eerie indeed.
8. This is how one of the 'votaries' of the procedure described the family-planning programme now in a phrase made famous as the title of a documentary by the film-maker Deepa Dharaj.
9. That anything at all is now possible, that there are now new actors in the drama, is illustrated by the fact that even as I write this, I was called by a US-based public relations agency, IPAN, with a branch in India inaugurated after liberalisation, asking me to be on an 'advocacy panel'. The panel, comprising among others, a prominent woman journalist on the AIDS bandwagon, the Pathfinder Foundation, a prominent doctor, a celebrity, and a movie star, would make public appearances pleading for reproductive choice. The project was to be run by the organisation Commercial Marketing Strategy (CMS) with funds from USAID to launch the injectable Depot Medroxy Progesteron Acetate (DMPA) in three cities in north India. Ogilvie Health Care was also involved in the project. FPAI would train the doctors involved and CMS would establish 20 'dedicated DMPA outlets' manned by doctors and counselors and equipped with toll free telephones. DMPA would be supplied at the cost of Rs 100 at the outlets, while it costs Rs 150 in the open market. It is to be used every three months under the guidance of the doctor and counselor at the dedicated outlets. The panelists would appear on TV programmes and workshops with doctors; newspaper space would be guaranteed. Currently the programme was to cater to the private sector.

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2

RED HERRINGS: MALTHUSIANISM AND NEO-MALTHUSIANISM

In the preceding chapter, we surveyed the evolution and growth of the family-planning programme in India. The single most important point that emerges is that the programme has quite simply failed to take off. The programme also reveals a peculiar pattern: a programme strategy is adopted with enthusiasm; it appears to work for some time before soon running aground. A new strategy is then adopted, frequently centring on some new technology, often inspired by international agencies. But each new twist in the programme strategy appears to lead up a blind alley. Indeed, it would not be exaggeration to state that the history of family planning in India is a history of monumental failures. As P.C. Joshi perspicaciously and succinctly stated so many years back, "'Family planning has failed, but family planning must succeed" runs the refrain of policymakers' (Joshi, 1974: 79). The question that arises, of course, is why is this so? Is the problem one of strategy? Is it the question of technical choices alone? Is it—as is so frequently thought—due to the superstitious beliefs held by people who need education about the virtues of a small family? But then even this approach failed to yield commensurate results. While these are no doubt important and relevant issues, the questions addressed here are substantially different. Could it be that there is some fundamental problem in the approach, in the manner in which the problem is posited? Has the conceptualisation of the question ignored certain critical and central issues? Is this due to the overarching influence of the ideas of Malthus on the perception of the issue? We shall turn our attention now to these questions.

So overwhelming is the influence of Reverend Thomas Malthus that no examination of the question of population can avoid commencing with his writings.[1] But before considering his writings and

placing them in the social context of his times, it might perhaps be salutary to briefly survey the views of some eighteenth-century moral philosophers of Europe on the subject of population.

Concern about the relative sparseness of the French population (on which, of course, there was then no data), compared with England, and the latter country's greater robustness and imperial might, was fairly widespread among French intellectuals in the eighteenth century (Vigarello, 1990: 33). Montesquieu was one of the most influential writers on the population question at this time. His work *Lettres Persanes*, published in 1721, made a profound impact on Enlightenment thinkers both in Scotland and in the Continent. Written in the form of an imaginary correspondence, the book examined a number of social issues of the day. In his view, the French nation was degenerate and the population, therefore, declining. In a large number of letters he examined the reasons for the decline of the population. Echoing the Physiocrats, he attributed the decline to the influence of the Catholic Church on the one hand and the oppressive economic policies—in particular agricultural taxation of the aristocracy—on the other. He called for thoroughgoing economic reforms to halt the decline of the population. Comparing contemporary France to a supposedly populous ancient Greece, he argued that a government must be concerned with increasing the population through the provision of employment. This, coupled with political liberty led, in his view, to the wealth of a nation (Tomaselli, 1988: 26).

Indeed, one of the first writings in the newly emerging scientific discipline of political economy, concerned with understanding the systematic working of the economy, to discover its hidden laws, was by Victor Riqueti, Marquis de Mirabeau. One of the founders of the Physiocratic school, Mirabeau achieved great fame as the author of a book called *The Friend of Mankind*, or *Treatise on Population*, published in 1756 (Gordon, 1991). He argued that population was one of the essential requirements for economic growth and that the function of state policy should be to induce population growth.

Hume did not echo Montesquieu's views on the populousness of ancient civilisations, nonetheless he noted that compared to the commonwealth of the ancient world 'where of course a great equality of fortune prevailed', the 'situation of affairs in modern times with regard to civil liberty as well as equality of fortune, is not near so favourable either to the propagation or happiness of mankind'

(Hume, cited in Tomaselli, 1988: 19). The populousness of a nation was related to and depended upon happiness, equality, liberty, and industriousness. In his words,

> ... every wise, just, and mild government by rendering the condition of its subjects easy and secure, will always abound most in people, as well as in commodities and riches .... If everything else be equal, it seems natural to expect, that, wherever there are most happiness and virtue, and the wisest institutions, there will also be most people. (ibid.: 17–18).

One of the most prominent intellectuals of the Enlightenment period, who studied the population question was Jean-Jacques Rousseau. His ideas on the question of population were also distinctly pro-nationalist. In *Du Contrat Social*, published in 1762, he wrote:

> What is the end of political association? The preservation and prosperity of its members. And what is the surest mark of their preservation and prosperity? Their number and population .... The rest being equal, the government under which, without external aids, without naturalisation or colonies, the citizens increase and multiply most is beyond question the best. (Rousseau, cited in Tomaselli, 1988: 23)

The most influential of the Enlightenment texts, the *Encyclopedie* of 1765 edited by Diderot, drew largely on the work of Montesquieu and Hume. Its entry on population noted that *ceteris paribus* the countries where felicity flourished were those that were also endowed with large populations. These were also countries where the government was least complex and where there existed relative equality and liberty.

The importance of employment to population was further developed in Sir James Steuart's *An Enquiry into the Principles of Political Economy*, a rather sophisticated discourse on the population question published in 1767. Modern society, he said, was complex and it was on the basis of the complex division of labour and the consequent exchange of goods and services that the wealth of a nation was built. Full employment and industriousness were both essential. Steuart's observations are also precursors of ideas Malthus later developed; the Malthusian seed was, in a manner of speaking, sown in his theories. To quote one crucial passage:

> Every individual is equally inspired with a desire to propagate. A people can no more remain without propagating, than a tree without growing.[2] But no more can live than can be fed; and as all augmentations of food must come to a stop so soon as this happens, a people increase no more; that is to say, the proportion of those who die annually increases. This insensibly deters from propagation, because we are rational creatures. But still there are some who, though rational, are not prudent; these marry and produce. This I call vicious propagation. Hence I distinguish propagation into two branches, to wit, multiplication, which goes on among those who feed what they breed, and mere procreation, which take place among those who cannot maintain their offspring. This last produces a political diseases, which mortality cures at the expense of much misery .... How to propose a remedy for this inconveniency without laying some restraint upon marriage; how to lay a restraint upon marriage without shocking the spirit of the times, I own I cannot find out. (Steurt, cited in Tomselli, 1988: 15)

What is striking about the commentaries of all these thinkers is their appreciation of the enormous complexities of the problem and the phenomenal number of issues that are seen in relation to population. These encompass a wide range of socio-economic issues including wages, employment, the conditions of work, security in old age, parental perception of children, the status of women and so on. The second feature these thinkers share is that they regard population as the dependent variable, responding to changes in a wide spectrum of interlinked socio-economic determinants. Population, then, is the effect of changes in a complex web of interacting socio-economic factors. Strikingly, they are all unanimous in their views about the desirability of large populations which are associated with plenitude, equality, and liberty. Finally, it is the very structure of society that influences and shapes issues of population.

By the late eighteenth century, however, the perception of the population question had altered fundamentally. The reasons for this shift in perception are enormously complex and are to be sought in the socio-economic milieu of those turbulent times. We shall explore some of them shortly after examining the writings of Malthus.

This is yet another instance of that common occurrence in the history of the sciences: the more or less simultaneous 'discovery' by more than one person of a phenomenon, or indeed an idea. All too frequently, of course, as in the case of evolution, history forgets all but the major, or more acceptable actor, so that while the theory of

evolution is associated with the name of Darwin, A.R. Wallace's simultaneous discovery is not common currency.

Among the numerous predecessors of Malthus, two deserve mention. Robert Wallace in *Numbers of Mankind*, published in 1753, calculated the number of progeny of one couple under different sets of conditions. And Benjamin Franklin in a pamphlet published in 1755 entitled *Observations Concerning the Increase of Mankind and the Peopling of Countries*, argued that the population of America tended to increase geometrically, doubling every 25 years (Gordon, 1991: 183). Indeed Malthus, in the first edition of his work, acknowledged the fact that numerous other writers had already put forward the population growth argument. But it was Malthus who stole the limelight; it was his name that became common household knowledge; his ideas that were eponymously named. The historic work *An Essay on the Principle of Population* (hereafter referred to as *Essay*) was first published anonymously but to resounding success in 1798. Malthus set forward two basic propositions: 'First, that food is necessary to the existence of man. Secondly, that the passion between the sexes is necessary and will remain nearly in its present state' (Malthus, 1970: 13). In response to Godwin's 'unphilosophical' (that is, unscientific) speculations on the moderation of sexual passion, Malthus wrotes one of the most famous, or notorious, passages in the social sciences.

> Assuming my postulates as granted, I say, that the power of population is indefinitely greater than the power in the earth to produce subsistence of man. Population, when unchecked, increases in a geometric ratio. Subsistence increases only in an arithmetic ratio. A slight acquaintance with numbers will show the immensity of the first power in comparison of the second. (ibid.: 16)

It followed, therefore, that population would increase as long as food was available. According to Malthus, when numbers grow beyond that point, the growth of population is halted by two means; one he called the positive checks, that is, hunger, famine, and pestilence; and the other, preventive checks, that is, 'a foresight of the difficulties attending the rearing of a family acts as a preventive check' (ibid.).[3] The former inevitably, and 'naturally', fall on the lower classes of society. To attempt to raise the standard of living of the lower classes by increasing wages would, through the operation of

the laws of nature, be rendered ineffectual. Their population would then only increase further, till checked by a subsistence crisis. Thus emerges an iron law of wages: the subsistence wage is the just wage, because if wages are higher, population growth occurs till checked by poverty.

Poverty, then, was seen as a natural condition of human existence and not as a product of human institutions. The role of the poor was to accept misery for 'the misery that checks population falls chiefly, as it always must do, upon that part whose conditions is lowest in the scale of society' (Malthus, 1970: 16). The rich are in no way responsible for poverty; they are enjoined not to exert themselves to do something about it for 'no possible contributions or sacrifices of the rich, particularly in money, could for any time prevent the recurrence of distress among the lower members of society' (ibid.).

Malthus was opposed to relief for the poor under what was known as the Speenhamland System. In his view, relief would only mean a deterioration of the general condition of not only everyone else but also that of the poor themselves.[4]

> The poor laws of England tend to depress the general condition of the poor in these two ways. The first obvious tendency is to increase population without increasing the food for its support .... Secondly the quantity of provisions consumed in work houses upon a part of the society that cannot in general be considered as the most valuable part diminishes the shares that would otherwise belong to the more industrious and more worthy members and thus in the same manner forces more to become dependent. (ibid.: 48)[5]

Malthus was thus a trenchant partisan to one of the most bitter debates of the day relating to the reform of the Poor Laws. Indeed his views heavily influenced the passage of the Reform Bill in 1834 (Cole, 1946).

What was the Poor Law reform? How did the need for change in the Poor Laws arise? Customarily, in England since the Elizabethan times, the maintenance of the poor and disabled was the responsibility for the local community, the parish. The parish church obtained a tithe—one-tenth of the income of every member of the community—a part of which was made over to the needy in the parish. However, the commercialisation of agriculture and the consequent takeover by landlords of common pasturage between the sixteenth and eighteenth centuries it what came to be known as the Enclosure Movement, not

only sundered feudal relations but also, through pauperisation of a section of the peasantry, vastly increased the magnitude of poverty even as it enriched the landlords (Hobsbawm, 1977). The poor were earlier tied by feudal bonds to their parishes; now, not only did these bonds cease to exist, the poor were beckoned by the prospect of jobs, however unfamiliar, in the newly opened industries in the towns. Painful as the prospect of leaving an ancestral hearth was, more and more poor were left with no other option.

In the words of Hobsbawm,

> But ... an industrial economy needs labour, and where else but from the former non-industrial sector was it to come from? The rural population at home ... were the most obvious sources supplemented by the miscellaneous petty producers and labouring poor. Men must be attracted into the new occupations, or if—as was most probable—they were unwilling to abandon their traditional way of life—they must be forced into it. Economic and social hardship was the most effective whip; the higher money wages and greater freedom of the town the supplementary carrot. (ibid.: 65)

Roving bands of paupers seeking employment were thus a common sight in the English countryside over these years.[6] Rootless and jobless, they were ever-present sources of political trouble, of potential and threatening lawlessness. What then was to be done about them?

Malthus was very forthright in his views: 'The truth is that the pressure of distress on this part of the community (viz., the lower classes) is an evil so deeply seated that no human ingenuity can reach it' (Malthus, 1970: 65). The palliative he suggested was the 'total abolition of all the present parish laws' to facilitate free movement of labour as dictated by the commands of the market. For those beyond the pale of what demographers rather aseptically call push and pull factors, namely, those who for reasons of ill health, age, and debility, could not respond to the beckoning of market forces, Malthus recommended work-houses. These work-houses were to be made as unattractive as possible in order to distinguish the deserving from the non-deserving poor; the latter could not be admitted into the work-houses. He recommended, 'the fare should be hard, and those that were able to obliged to work'.[7]

Thus it is that the Poor Law of 1834, deeply congealed with Malthusianism, claimed that 'public relief of destitution out of funds raised by taxation ... devitalized the recipients, degraded their character

and induced in them general bad behaviour, creating a wider pool of destitution' (cited in Jayal, 1987: xvii). The policy prescription that emerged was the principle of 'less eligibility' according to which no able bodied person could be helped by public relief to a level comparable to the labourer of the lowest class. If this was done, it was maintained, it would make the working classes less industrious, more prone to laziness than they already were, more shiftless, and would enable them to enter 'the more eligible class of paupers'.

In the second edition of his work, published in 1803, Malthus's tone was more assured, more 'scientific' and less polemical. But while the principle of population as a natural law, provided the *scientific* basis for Poor Law reform, the second edition argued that the poor had no *moral* right to relief.

> A man who is born into a world already possessed, if he cannot get subsistence from his parents on whom he has a just demand, and if the society do not want his labour, has no *right* to the smallest portion of food, and, in fact, has no business to be where he is. At nature's mighty feast there is no vacant cover for him. She tells him to be gone, and will execute her own orders, if he do not work upon the compassion of some of her guests. If these guests get up and make room for him, other intruders immediately appear demanding the same favour ... . These guests learn too late their error, in counteracting those strict orders to all intruders, issued by the great mistress of the feast, who wishing that all guests should have plenty, and knowing that she could not provide for unlimited numbers, humanely refused to admit fresh comers when her table was already full. (emphasis added) (Malthus, cited in Meek, 1977: 9)

What is all too often forgotten in examining the work of Malthus is that it is primarily a tract against the 'Utopian Socialists' of the age, namely, Godwin and Condorcet.[8] His work was, in the first instance, a rejoinder to the ideas of the perfectibility of mankind advanced by them. In other words, it was a political tract against the hope for social progress aroused by the French Revolution of 1789 and the collapse of the *ancien règime* (Harvey, 1974: 515). Indeed the frontispiece of the first edition of the *Essay* makes this explicit; the title reads 'An Essay on the Principle of Population as It Affects the Future Improvement of Society with Remarks on the Speculations of Mr. Godwin, M. Condorcet and Other Writers'. Malthus wrote:

> Godwin's work on *Political Justice* is to shew that the greater part of the vices and weaknesses of men proceed from the injustice of their political and social institutions and that if these were removed and the understandings of men more enlightened, there would be little or no temptation in the world to evil. However, this is entirely a false conception, and, independent of any political or social institutions whatever, the greater part of mankind, from the fixed and unalterable laws of nature (viz., the law of population) must ever be subject to the evil temptations arising from want. (Malthus, cited in Meek, 1977: 3)

The French Revolution, with its rallying cry of *liberté*, *egalité*, and *fraternité* aroused great hopes for the advancement of mankind among some sections of the population. Wordsworth, for example, wrote, 'Bliss was it that dawn to be alive' when he heard of the storming of the Bastille. The Revolution also aroused great fears in the minds of the propertied. 'The awakening of the labouring classes after the first shocks of the French Revolution made the upper classes tremble', noted Lady Frances Shelley in her diary (Thompson, 1982: 56). Lord Cockburn wrote, 'Everything rung and was connected with the Revolution in France. Everything, not this thing or that thing, but literally everything was soaked in this one event' (Meek, 1977: 3).

Fears of 'the mobs taking over' were rampant; indeed there was ample evidence that these fears were not entirely misplaced and were certainly not paranoid. The poor, comprising a motley lot of occupations but held together by memories of a communitarian moral economy, and both distrustful and hostile to the emergent market economy, were inspired by a long tradition of popular dissent—of Levellers, Diggers, Ranters, and Chilianism (Hill, 1984: 127). Groups such as miners and self-employed artisans saw wages as a matter of custom. They expected prices to be regulated by custom also. The new 'God-given laws of supply and demand', whereby any scarcity led to soaring prices had not won popular acceptance.[9] An elaborate code of custom regulated the price, the size and the quality of a loaf of bread. And a price rise or any move to impose standardised measures resulted in a riot. Bread riots which occurred in 1764, 1766, 1783, and 1788 marked the landscape of eighteenth century England (Thompson, 1982: 69).

Profoundly influential on the rebellious poor was Paine's *Rights of Man*, published in 1791. As Thompson has noted, 'The seed of *Rights of Man* was English; but only the hope brought by the American and French Revolutions enabled it to strike' (ibid.: 37). In what was

considered the foundation text of the English working class movement, Paine thundered:

> When the rich plunder the poor of his rights, it becomes an example to the poor to plunder the rich of his property .... The aristocracy are not the farmers who work the land but are mere consumers of the rent. (Paine, cited in Thompson, 1982: 92)

Paine then elaborated on a host of social security arrangements, in addition to political enfranchisement of the people and the abolition of hereditary privileges, as a solution to the problems of the day. These included general education, old age pensions, maternity benefits, funeral funds, unemployment benefits, etc., not as a matter of grace and favour but of right.

Equally influential and widely circulated was a pamphlet by Alexander Kilham entitled *The Progress of Liberty*. The writings of Voltaire and Rousseau also made the rounds. The popularity of such democratic ideals seriously worried the establishment. They found their ideologue, their prophet, in Malthus. For had he not 'scientifically' proved that by the eternal laws of nature poverty was inevitable? And that the best thing to do about it was to do nothing?

Malthus's work may also be read as a tract on the inherent nature of man. Celebrated, structured, created as the natural man is the quintessential bourgeois man, self-seeking, competitive, and heartless; the 'rational' profit-maximising individual of neoclassical economics. Society for him, comprised an assemblage, an agglomeration of such individuals. It was 'naturally' a 'society divided into a class of proprietors and a class of labourers' with 'self love the main spring of the great machine' (Malthus, 1970: 112). It is not surprising, therefore, that Malthus' writings greatly influenced that other great figure of the nineteenth century, Charles Darwin (Flew, 1970). It was, in a sense, zeitgeist, but the spirit was not so much of an age as of a class that found resonance in Malthus. It must not be forgotten, however, that in those troubled times 'a benignant spirit was abroad'.[10]

It is in the context of the debate on the nature of man and the perfectibility of humankind, in this volatile period that we must locate Malthus. He was, then, one of those, who through recourse to 'scientific' laws of eternal and unchangeable nature, argued against the possibility, indeed the desirability, of changing social and political institutions that had outlived their days.

What, in fact, was the 'scientific' claim of Malthus? Did it lie in the fact that his language was cloaked in the idiom and tropes of the science of the times? Was it to be found in the insistent and constant use of rates and ratios? Let us study an example or two. Malthus wrote: 'These operations of what we call nature have been conducted almost invariably according to fixed laws. And since the world began, the causes of population and depopulation have probably been as constant as any of the laws of nature with which we are acquainted' (Malthus, 1970: 51). Or again, 'It has appeared, that from the inevitable laws of nature some human being must suffer from want. These are the unhappy persons who in the great lottery of life, have drawn a blank' (ibid.).

'The constancy of the laws of nature and of effects and of causes' wrote Malthus, 'is the foundation of all human knowledge', although he conceded that God may change the laws if he so wishes. While Malthus's admiration for Newton is acknowledged, less attention has been paid to the influence of eighteenth century positivist science, Newtonian science, on Malthus. Central also is the concept of equilibrium, of a stable state of population, which is the equilibrium point of two forces, the capacity to procreate and the ability to produce food (Gordon, 1991). Malthus regarded this balancing of forces as 'an obvious truth' (Malthus, 1970: 52).

This truth is, however, not so obvious. The major propositions, or assumptions, that population when unchecked grows in a geometric ratio while food can grow only in an arithmetic ratio, the foundation of the Malthusian edifice, are, in fact, entirely arbitrary. It is on the basis of these arbitrary propositions that the entirely complex issue of the relationship between resources and population is examined. If an empirical observation of society provides evidence of poverty, then syllogistically it follows, that there exists population pressure. The problem, in other words, is of the method used. A famous analogy would illustrate the problem at the very heart of the Malthusian method.

Socrates, unable to bear political persecution due to his supposedly heretical writings, committed suicide by drinking hemlock. A logician of Malthusian persuasion when asked to examine the cause of his death may argue as follows:

All men are mortal.
Socrates was a man.
Therefore Socrates is mortal.

This syllogism, used to account for Socrates' death makes no reference to heresy, political persecution, or hemlock. The logic, of course, is impeccable; and it is empirically true that all men are mortal as indeed that Socrates was a man. But a syllogism like this one does not, in fact, focus on the *cause* while appearing to offer an explanation. To take the syllogistic argument a little further:

> Drinking hemlock causes death.
> Socrates drank hemlock in 399 BC.
> Therefore Socrates died in 399 BC.

This syllogism might be acceptable to an expert in forensic medicine but not to a social scientist. The apparently logical process here again offers only a partial explanation of the cause of the phenomenon under study (Gordon, 1991).

Given Malthusian assumptions, the solution to the problem follows axiomatically. In other words, out of a complexity of historically determined variables which are interactive, this method takes into account an isolated few variables, makes some assumptions regarding the behaviour of their relationship, tests empirically the validity of the outcome of the *association* and then arrives at a deduction of *causality*. This, clearly, is not methodologically valid. What Malthus arrives at is not a theory; he makes certain statements of facts but fails to arrive at any coherent explanation.

The problem with Malthus's method becomes more explicit if his work is examined in the context of the debate on the Corn Laws—a debate that tore apart English society as few issues of the time did. Thompson has noted, for example, that during the passage of the Corn Laws in 1815, 'the houses of Parliament were defended with troops from the menacing crowds' (Thompson, 1982: 315).

The debate on the Corn Laws was related to the debate on free trade policies, or as is better known, on laissez-faire policies. It was related also to a certain vision of society, a debate that attempted to identify which class in the nation was more dynamic in its contribution to the wealth of the nation. The rising class of industrialists, the nouveau bourgeois, was opposed to laws restricting the import of wheat—the price of which had increased steeply during the Napoleonic wars. The class of the landlords, however, benefited from the high price and were, therefore, opposed to free trade, to the free import of wheat from the surplus production in the USA, which would, in their view,

lower prices. The free traders argued that these 'unnatural' restrictive laws increased the price of food and, therefore, of the wages that had to be paid. An increase wage bill cut into profits and, therefore, it was argued, into capital that could be productively invested to increase the wealth of the nation (Meek, 1977). The industrial class prided itself on its dynamism, vigour, parsimony, and, indeed, industry. The landlords were characterised as effete, parasitic rent-seekers, self-indulgent, non-productive and given to conspicuous consumption. As the battle lines were drawn on the Corn Laws, landlords—who then dominated the Parliament—sought protection from imports, while the manufacturing class sought free trade (Huberman, 1981). The battle was joined by the two most famous political economists of the day—Malthus and Ricardo; the former as a partisan of the interests of the landlords and the latter as a partisan of the interests of the manufacturing class.

Malthus in his *Principles of Political Economy* recognised that there was a problem to be solved in the accumulation of capital in society. The capitalist saves, invests in production, sells the product at a profit, and reinvests a part of the profits to set off yet another cycle of production. He, however, needs buyers for the product. This demand for products, Malthus was certain, could not emanate from the lower classes; it was self-evident that their purchasing power was limited. The problem of effective demand was, he argued, very crucial in an economy. He argued that effective demand could only arise from those classes—landlords and functionaries of the church and state—who were outside the production process (Harvey, 1974). Effective demand emanating from the unproductive classes of society was, therefore, a vital force, both in stimulating accumulation of capital and in the expansion of employment. Indeed labour may be unemployed simply due to the failure of the upper classes to consume.

Now this theory of effective demand does not sit easily with the theory of population. Malthus advocates in the latter that the power to consume be withheld from the lower classes; while in the former he endorses the profligate consumption of the upper classes. He attempts to reconcile this contradiction by arguing that the upper classes do not increase their numbers for fear of coming down in life; unlike the lower classes who breed imprudently. The law of population is consequently disaggregated into one law for the rich and another for the poor. This is, in effect, a denial of its salience and power as a 'natural law', for

evidently no one would argue that the law of gravitation operates differently in different places or differently for different people!

Malthus does not explain why effective demand cannot be generated by increasing the purchasing power of the labouring classes. He simply dismisses the possibility as illogical because 'no one will ever employ capital merely for the sake of demand occasioned by those who work for him' (cited in Harvey, 1974: 520). This could happen in only one instance; if the labourers 'produce an excess of value above what they consume' (ibid.). And Malthus denies that this could happen. It is, in fact, this concept—that Malthus refuses to entertain which forms the core of Marx's concept of surplus value (ibid.).

In the *Essay* Malthus does not consider the possibility that more people can raise proportionately more food. But in the *Principles of Political Economy* he does examine this as a possibility before dismissing it, by focusing upon the law of diminishing returns.[11] While Ricardo made short shrift of the concept of effective demand enunciated by Malthus, he accepted Malthus's views on population and the law of diminishing returns. The version of population theory that Ricardo and his school of political economy utilised was based explicitly on the proposition that the law of diminishing return is an inescapable property of agricultural production. But the law of diminishing returns is as chimerical, as contingent, as the iron law of wages.

In the words of Engels:

> Where has it been proved that the productivity of land increased in arithmetical progression? The area of land is limited—that is perfectly true. But the labour power to be employed on this area increases together with the population; and even if we assume that the increase of output associated with this increase of labour is not always proportionate to the latter, there still remains a third element—which the economists, however, never consider as important—namely, science, the progress of which is just as limitless and at least as rapid as that of population. (cited in Meek, 1977: 26)

Although we cannot, in our times, help being cautious about the boundless beatitudes of science envisioned by Engels, we cannot refute his argument that the law of diminishing returns is inapplicable to conditions of changing technology and methods of production.

A detailed examination of Malthus and his work is unavoidable mainly because even most contemporary discussion of the relationship

between resources and population are overshadowed by his ideas and methods. Indeed, the Malthusian understanding spills over into a number of seemingly unrelated issues such as affirmative action and is at the heart of a highly charged contemporary debate on immigration. We shall briefly consider what Marx and Engels had to say on the population question. But before we do so let us note *en passant* that the experience of England in the nineteenth century, when an increased population was accompanied by dramatic improvements in standards of living put paid both to the iron law of wages and the law of population. The Malthusian spectre of population growth was laid low for the time being.

Marx and Engels, besides reserving a number of choice epithets for Malthus, argue that there is no fixed, universal, eternal law of population. Marx notes that social factors create a 'law of population peculiar to the capitalist mode of production', adding that 'in fact every particular historic mode of production has its own special laws of population, historically valid within that particular sphere' (Marx, 1976: 783–84).

Central to capitalism is the surplus value that is generated in the production process and is appropriated by the capitalist as interest, profit, or rent. Marx points out that the working population under capitalism produces both the surplus and a 'relative surplus population'. The relative surplus population comprises that section of the labour force not employed by capital currently, depending upon both capital accumulation and the technology deployed. Underlying the law of population is, therefore, the compulsions of capitalist production.

The relationship between the rate of capital accumulation, the size of the labour force, and the technology employed thus determines what proportion of the population is unemployed at any point of time and forms the relative surplus population. In order to generate greater accumulation over time, there is a change in the composition of capital, a greater part now being constant capital (that is, that which is expended on the technical aspects of production), with a reduction in the variable part of capital (that is, the labour utilised). Thus, according to Marx it is:

> ... capitalist accumulation itself that constantly produces, and produces in the direct ratio of its own energy and extent, a relatively redundant working population, i.e., a population which is superfluous to capitals average requirement for its own valorisation, and is therefore a surplus population. (Marx, 1976: 784)

He adds:

> The labouring population therefore produces, along with the accumulation of capital produced by it, the means by which it itself is made relatively superfluous .... If a surplus labouring population is a necessary product of accumulation or of the development of wealth on a capitalist basis, this surplus population also becomes, conversely, the lever of capitalist accumulation, indeed it becomes a condition of existence of the capitalist mode of production. It forms a disposable industrial reserve army, that belongs to capital quite as absolutely as if the latter had bred it at its own cost. Independently of the limits of the actual increase of population, it creates for the changing needs of the self-expansion of capital, a mass of human material always ready for exploitation. (Marx, 1976: 798)

In other words, the production of a relative surplus population, an industrial reserve army, is seen by Marx as being both historically specific and internal to the capitalist mode of production. This mass of unemployed labour then acts both as a disciplining force on the labouring population and serves to depress their wages.

Marx was not arguing that population growth per se was a mechanical product of the law of capitalist accumulation, nor was he arguing that population growth per se did not affect the situation. But he was arguing very specifically, contrary to the position of Malthus and Ricardo, that the poverty of the labouring classes was the inevitable product of the capitalist process of accumulation. Poverty then was not to be explained away as a natural condition for a section of society, that is, as a natural law.

We have noted that the nineteenth century English experience of a surge in population accompanied by rising per capita income, discredited the ideas of Malthus. As England completed her industrial and health revolutions, and as birth rates subsequently commenced a secular decline, Malthusianism lost its bite, its urgency, its pungency. It was not, however, put to deserved rest. It continued to be resurrected as an explanation of poverty in other parts of the world. Malthus himself would probably have turned in his grave had he learnt that the influence of his ideas was apparent for instance in the British Government's decision to withhold relief during the famine of 1870 in India. At that point India supported one-fourth the population it supports today; a note on which to turn to Malthus in his resurrected form.

II

India was integrated into the world of capitalism with the battle of Plassey in 1757. The colonial loot of the 'jewel' in Britain's crown was both instantaneous and staggering. It has been estimated that the treasure taken from India alone between Plassey and Waterloo was an astounding £500 to £1,000 million (Patnaik, 1973). Its impact on the industrial revolution in England was equally instantaneous and has been noted in the following words: '... the Bengal plunder began to arrive in London, and the effect appears to have been instantaneous .... At once in 1759, the Bank (of England) issued 10 and 15 pound notes ... and the industrial revolution began with the year 1760' (Adams, cited in ibid.: 198).

India thus provided a large chunk of the capital for England's industrialisation and simultaneously began the process of her own impoverishment and deindustrialisation. And India was 'systematically deindustrialised' (Hobsbawm, 1977: 151) and became in turn a market for Lancashire cottons: in 1820 India imported 11 million yards; by 1840 the quantity stood at 145 million yards. Unable to bear the unfair competition, spinners and weavers in India suffered destitution. The spinning and weaving industry in urban India was wiped out; the rural artisans, immiserised, were ready victims of the famines that loomed over India in the nineteenth century.

The ideas of Malthus were now resurrected as an explanation of India's poverty. As far back as in the early nineteenth century, European travellers, setting the tone for later colonial administrators supervising the plundering of India, invoked Malthus as an explanation for poverty in India. For example, Abbe Dubois,[12] after surveying the destruction of the Indian weaving industry and the consequent pauperisation of her artisans, and indeed after linking this to the mills of England, remarked:

> Of these causes (of misery) the chief one is the rapid increase of population. Judging by my own personal knowledge ... of Mysore and the districts of Baramahl and Coimbatore, I should say that they increased by 25 per cent in the last 25 years .... Some modern political economists have held that a progressive increase in the population is one of the most unequivocal signs of a country's prosperity and wealth. In Europe this argument may be logical enough, but I do not think that it can be applied to India; in fact, I am persuaded that as the

> population increases, so in proportion do want and misery. For this theory of the economists to hold good in all respects the resources and industries of the inhabitants ought to develop rapidly; but in a country where the inhabitants are notoriously apathetic and indolent, where customs and institutions are so many insurmountable barriers against a better order of things, and where it is more or less a sacred duty to let things as they are, I have every reason to believe that a considerable increase in the population should be looked upon as a calamity rather than as a blessing. (Dubois, 1906: 93–94)

Thus is assiduously constructed the image of the Other, of Orientalism, of seething poor overpopulated tropics, in a swoon of customs and habits, ineradicable and unchanging (Said, 1991). Colonial policy is exonerated the responsibility of creating a relative surplus population in India. In addition to the destruction of her cottage industry, British agricultural policy—of commercialisation and revenue extraction through the Permanent Settlement Act—impoverished vast sections of the Indian peasantry (Patnaik, 1973). This dispossessed peasantry did not have the option that their English counterparts did, of turning into proletarians, working in the industries, for British free trade policies actively hindered industrialisation. India was thus integrated into the world economy as an exporter of primary commodities with a virtually stagnant, vast, and immiserised agricultural sector and no industrial sector to speak of. The spectre of Malthus loomed large over India even in the nineteenth century when there was little population growth and the Indian population was stalked by periodic and terrible famines.

Subsequently, in the late nineteenth century, we witness the birth of a new 'avatar' of Malthusianism, namely, neo-Malthusianism. Malthusianism and neo-Malthusianism are not conceptually or methodologically distinct. They differ insofar as the victims of their ideas or methods are concerned. While Malthusians were concerned with the poor of their own countries, neo-Malathusians looked across the seas at the poor in developing countries. And while Malthusians spoke of moral restraint, neo-Malthusians came equipped with contraceptive technology. The parents of neo-Malthusianism were the eugenists and birth controllers.

Charles Darwin's *The Descent of Man* published in 1871, provided a significant measure of inspiration to the birth of the eugenics movement (Greer, 1984). The ideas of competitive struggle, natural selection, and the survival of the fittest, when applied to human populations

had frightening consequences, not to mention deep ethical and moral implications. Racial purity and improvement of the racial stock were the prime concerns of the eugenics movement. The eugenics movement was named by one of its illustrious founders, a cousin of Darwin's, Francis Galton. Galton pioneered the use of statistics on human populations. A.R. Wallace, who co-discovered the process of evolution with Darwin, argued in an essay entitled 'The Action of Natural Selection on Man':

> At the present day it does not seem possible for natural selection to act in any way so as to secure the permanent advancement of morality and intelligence, for it is indisputably the mediocre, if not the low, both as regards morality and intelligence who succeed best in life and multiply fastest. (cited in Greer, 1984: 257)

Here again we find a scientist asserting something utterly unproven and probably unprovable as something 'indisputably' true. He was obviously stating something merely as a matter of faith. He nonetheless inspired Jane Hume Clapperton who published the principal text of eugenics, *Scientific Meliorism* in 1885. 'The racial blood', she wrote,

> ... shall not be poisoned by moral disease. The guardians of social life in the present day dare not be careless of the happiness of coming generations, therefore the criminal is forcibly restrained from perpetuating his vicious breed. The type will disappear whilst evenly balanced natures, the gentle, the noble, the intellectual, will become parents of future generations, and the purified blood and unmixed good in the veins of the British will enable the race to rise above its present level of natural morality. To promote the contentment of congenital criminals within their prison home, where they are detained for life, an alternative to celibacy might be offered, viz., a surgical operation rendering the male sex incapable of reproduction. (cited in ibid.: 258)[13]

Francis Galton inaugurated the Eugenics Education Society and brought out a journal called *Eugenics Review*. He was also responsible for the founding of the biometric laboratory at University College, London, and its journal *Biometrica*. Galton's passion was the application of statistics to data on genealogies and the collection of data on the lineage of the pedigreed. He was firmly committed to the idea that only the brightest and best should be encouraged to breed. For Galton, eugenics would breed out the vestigial barbarism

of the human race, manipulating evolution to bring the biological reality of man into consonance with his lofty moral ideas of what mankind could and indeed should be. According to Galton, 'what nature does blindly, slowly, and ruthlessly, man may do providently, quickly and kindly' (Francis Galton, cited in Kevles, 1995: 12). Eugenics was thus a scientific substitute for the orthodoxies of the church, a secular religious faith.

Eugenics, therefore, had two sets of action on its agenda: the positive eugenics of Galton and the negative eugenics of Clapperton. Those who received the attention of the latter at one time or the other were criminals, the mentally retarded, the insane, those afflicted with tuberculosis, lepers, alcoholics, epiletics, the 'feeble minded', the 'degenerate', immigrants, and, of course, the poor, who apparently bred all these characteristics. For example, it was noted with alarm:

> In Degeneracy healthy aspirations no longer exist, the struggle for survival the higher in the organism against the lower having ceased and the cells having conformed in a mass to a lower grade of being .... There is no greater menace to a race than is furnished by such sturdy degenerates. (cited in Greer, 1984: 266)

The intelligence quotient (IQ) test was designed in part to select cases eligible for eugenic sterilisation.

Eugenics held great appeal for influential people on both sides of the Atlantic for a variety of reasons. It won the approbation of the fledgling scientific community of the time, who with scarcely disguised contempt for the nobility and the new rich, believed that the future of humanity was squarely tied to the virtues of the professional middle classes they themselves belonged to. Darwin, the most influential of scientists, himself canonised his cousin's ideas, writing, 'We now know, through the admirable labours of Mr. Galton, that genius tends to be inherited' (Kevles, 1995: 20). Given the overwhelming influence of Darwin (indeed the age is frequently referred to as the age of Darwin), it is not surprising that many commentators of this time introduced Darwinian metaphors to social arrangements. Social Darwinists, believing that biology was destiny, at least for the poor, thus began to identify an extraordinary series of social and behavioural facts as inheritable. It was not far from this to asserting that only the 'fit' should be encouraged to procreate and that the 'unfit' discouraged.

There were profound inconsistencies, not to mention logical absurdities, in the arguments of the Social Darwinists. One was, of course, that the unfit were by definition not given to wider social concerns; indeed they were often 'feeble-minded'—that catch-all category including the mentally subnormal and a whole range of social 'misfits'. They could thus hardly be called upon to sacrifice their reproductive rights for the larger good of society, for the future of the race. If voluntary eugenic measures were not of much use with this category of people, what about some element of coercion?[14] But coercion would violate that most sacred of economic and social doctrines of the day—in Darwinian times as in neo-liberal ones—namely, laissez-faire, by inviting state interference, and in one of the private areas of individual liberty at that. But was coercion really necessary since in the struggle for survival, nature red in tooth and claw, by definition the unfit would be weeded out?

Eugenics, however, held appeal to some of the most progressive people of the times, the Fabian Socialists like Shaw, Havelock Ellis, and the Webbs (all of them, curiously, and incidentally, childless), although Shaw is said to have typically declared that had eugenics been followed a couple of generations back, he would not have been around to improve humankind! Their argument for the Socialist Utopia was that since barriers of wealth and class precluded desirable marriages between people, removing class distinctions would result in many more biologically-desirable unions.

Thus Shaw wrote:

> To cut humanity up into small cliques, and effectively limit the selection of the individual to his own clique, is to postpone the Superman for eons, if not forever. Not only should every person be nourished and trained as a possible parent, but there should be no possibility of such an obstacle to natural selection as the objection of a countess to a navvy or a duke to a charwoman. (Shaw, 1965: 59)

Eugenics was also tied to the destiny of the imperial nation. Such a nation, it was felt, required much more than merely economic and military power. It also demanded an efficient way of ensuring that its population was kept fresh, energetic, efficient, and productive by ensuring that its fresh flow of population was mainly recruited from the 'better stock'. Imperial anxiety about national fitness was also occasioned by British fears of German naval strength and the Boer

War (1899–1902), which revealed what appeared to be shockingly low standards of health among male recruits, linking together questions of public health and national welfare. It was these anxieties, these fears, that led to the 1904 *Report on the Physical Deterioration of the Population*. It was these concerns too that led those other eugenists, Sidney and Beatrice Webb, to make their plea for a welfare state in their 1910 treatise on the need for state-sponsored public health, *The State and the Doctor* (Oakley, 1986).

In July 1913 the British Parliament passed the Mental Deficiency Act, granting the central authorities powers to detain and segregate the 'feeble-minded', a feature it believed would result in some diminution in the multiplication of the unfit. 'Defectives' subject to the Act were defined to include not only paupers and habitual drunkards, but also women on poor relief at the time of child-birth, or those found to be pregnant with an illegitimate child. The law, however, did not impose mandatory segregation of all mentally handicapped people, nor did it mention sterilisation (Kevles, 1995).

A prominent eugenist in Germany wrote:

> Because the inferior are always numerically superior to the better, the former would multiply so much faster—if they have the same possibility to survive and reproduce—that the better necessarily would be placed in the background. Therefore a correction has to be made to the advantage of the better. The nature [sic] offers such a correction by exposing the inferior to difficult living conditions which reduce their number. Concerning the rest the nature [sic] does not allow them to reproduce indiscriminately, but makes a relentless selection according to their strength and health conditions. (Hilter in *Mein Kampf*, cited in Bondestam and Bergstrom, 1980: 16)

The 'correction' he offered to nature's lethal ways was called the final solution. Adolf Hitler included among others, Jews, communists, homosexuals, and gypsies in his grand design.

Adolf Hitler's cabinet promulgated a Eugenic Sterilisation Law in 1933. Going far beyond the American laws, under the obviously more efficient Third Reich law, sterilisation was compulsory for all those who suffered from allegedly hereditary disabilities—whether or not the people concerned were institutionalised. These initially included feeble-mindedness, schizophrenia, epilepsy, severe drug or alcohol addiction, and physical disabilities that seriously interfered with movement, or were aesthetically offensive. The counsellor on

the Ministry of the Interior, who had drawn up the law, proclaimed, 'We want to prevent poisoning the entire bloodstream of the race. We go beyond neighbourly love; we extend it to future generations. Therein lies the high ethical value and justification for the law' (Kevles, 1995: 117). The Nazi sterilisation programme was initially independent of its anti-semitic policies. But as Hitler turned more overtly against the Jews, there occurred the merging of racial and eugenic policies with the regime promulgating marriage laws prohibiting the marriages of persons with mental disorders and with different 'racial' backgrounds. The swift slide from these measures to the Nuremberg laws of 1935 and the euthanasia programme are horribly well known. Less well known is that the precedent for eugenic laws in Germany had, in fact, been set in the US.

In the US, the eugenics movement gained momentum early in the twentieth century mainly at the instance of natural scientists convinced by Galton that 'genius' was a heritable characteristic. The rediscovery of Mendel's work in 1900 led to the formation of the American Breeders Association in 1903. In 1906, a Eugenics Section of the Association was established to 'emphasise the value of superior blood and the menace to society of inferior blood' (Hodgson, 1991: 10). The American eugenics movement involved itself with legislation to check 'unrestricted immigration', especially of those not Anglo-Saxon or Nordic, who were described as the 'annihilator of our native stock'.[15] Eventually, those permitted to immigrate were only 'pure Caucasians' who on an IQ test had acquired the minimum grade of 'C', the presumed average grade of the American population as shown in the army intelligence test scale.

The eugenists were also instrumental in initiating legislation and carrying out eugenic sterilisations on the institutionalised mentally 'subnormal', the epileptic, and the psychotic.[16] Although at that time no state as yet had legally authorised sterilisation, experiments on the 'unfit' were rampant. Dr Harry C. Sharp, physician to the Indiana State Reformatory, in 1899 pioneered the sterilisation of the unfit by vasectomy. The first state to pass sterilisation laws was Indiana in 1907. Over the next 10 years, 15 more states passed such laws. Included in the scope of these laws was the sterilisation of 'habitual' criminals, confirmed rapists, epileptics, the insane, drug addicts, idiots and the feeble-minded. The measures gathered support from a wide range of experts, in addition to eugenists and some influential members of the lay public. Supporters were found in many universities, especially in

the departments of biology, sociology, and psychology, and among doctors. Indeed, the eugenicist Leon F Whitney wrote, 'We cannot but admire the foresight of the (German) plan (of sterilising 4,00,000 people) and realise [that] by this action Germany is going to make herself a stronger nation.' He also observed that, 'the Negroes furnished six times as many sub-normals as did the native-born whites' (cited in Greer, 1984: 274).

By 1914, 30 states in the US had enacted new marriage laws or amended old ones. The majority of the statutes declared voidable the marriage of idiots and of the insane, and the others restricted marriage among the unfit of various types, including the feeble-minded and persons afflicted with venereal disease. The ostensible reason for such laws was that such people were incapable of making contracts, marital or otherwise, but in many of them, the restrictions were justified on eugenic grounds. The first state to pass such laws, Connecticut in 1896, prohibited marriage, and extramarital relations for the eugenically unfit; the maximum penalty for violation being three years' imprisonment (Kevles, 1995: 88).

Let us note that the victims of all this 'scientific' hysteria were the weak, the powerless, and the helpless. That the eugenist utopia continues to exert a powerful attraction, despite being shorn of its scientific halo, is evident in even current legislation and practice; regarding, for example, the introduction of hormonal implant contraceptives in the US. Women on welfare, with either a criminal record or a record of 'child neglect', must have Norplant implanted in order to be eligible for welfare. Thus the vast majority of women subjected to Norplant are Afro-Americans or Hispanics (Srinivas and Kanakamala, 1992: 153–33). Eugenic laws are currently on the books in 22 states in the US.

Eugenic laws, it need hardly be added, were deeply tinged also with racism. As Angela Davis observed:

> It was not until the media decided that the casual sterilization of two black girls was a scandal worth reporting that the Pandora's box of eugenic sterilization abuse was finally flung open. But by the time the case of the Relf sisters broke, it was practically too late: it was the summer of 1973, and the Supreme Court decision regarding legalizing abortion had already been announced in January. Nevertheless, the urgent need for mass opposition to sterilization abuse became tragically clear. The facts surrounding the Relf sisters' story were horrifyingly simple: aged

> 12 and 14 they had been unsuspectingly carted into an operating room, where surgeons irrevocably robbed them of their capacity to bear children. (Davis, 1983: 216)

Davis also noted that by 1976 a quarter of all native American women in the reproductive years were sterilised and argued that the hard won right to abortion for white women was, in fact, won on the backs of black women and other women of colour, subjected to decades of sterilisation abuse; indeed that the bourgeoise woman's movement, was a white woman's movement.

Meanwhile in London in 1930, the Eugenic Society, encouraged by the Report of the Joint Committee of the Board of Education, which found that 'mentally deficient parents create centers of degeneracy and disease which welfare work can never reach' (cited in Greer, 1984: 266) began concerted lobbying and propaganda for a Eugenic Sterilisation Bill. Associated with this effort were a press baron, the noted author H.G. Wells, Darwin's son, Major Darwin, and Julian Huxley. The last, who later became a lion of the population control movement, wrote:

> The principle of supplementing the segregation of defectives by sterilisation in certain cases is to my mind very important, and indeed very essential, if we are to prevent the gradual deterioration of our racial stock. (cited in ibid.: 270)

Eugenics was scientifically discredited by that famous biologist (and friend of India) J.B.S. Haldane. But it was Herman Mueller's discovery of mutation in the early 1940s that denuded it of the very last vestiges of scientific respectability. The eugenic lobby now turned to what they called crypto-eugenics or population control. In 1956, the British Eugenics Society decided in a resolution:

> ... the Society should pursue eugenic ends by less obvious means, that is by a policy of crypto-eugencis. The Society's activities in crypto-eugenics should by pursued vigorously, and specifically that the Society should increase its monetary support of the Family Planning Association and the International Planned Parenthood Federation. (cited in ibid.: 278)

This brings us to that other parent of the population control movement, namely, the birth control movement. Various streams of thought,

jostling uneasily with one another, congealed into the birth control movement in the nineteenth century gathering strength in the early twentieth century. One stream was that of the radical feminists, tracing their descent in modern times to Mary Wollstonecraft's publication in 1792 of *The Vindication of the Rights of Women.* These persons believed, and believed strongly, that it was women's right to control their own destinies, their own bodies. Access to birth control, then banned, was one element in their larger struggle for democratic rights.

The second stream was that of the socialists. Their ideas on birth control were coloured by the feeling that the burden of repeated pregnancies was harmful to the health of working women; and by the belief that it was in the interests of capitalists, who needed an unlimited supply of cheap labour and not of the working class, to have large populations. It was thus in the ranks of the International Workers of the World that the first stirrings demanding free access to contraception arose (Gordon, 1976). Thus, for instance, Emma Goldman, the prominent anarchist, attended the 1900 Neo-Malthusian Conference in Paris, calling on working women as a class to 'no longer be a party to the crime of bringing hapless children into the world only to be ground into dust by the wheel of capitalism and to be torn into shreds in trenches and battlefields' (cited in Hodgson and Watkins, 1997: 474).

The third and important stream, which came to dominate the birth control movement was that of the neo-Malthusian. Finally, the last and least significant was an offshoot of the Romantic movement, the free lovers, who believed in the liberating powers of the sexual act which, they believed should be untrammelled from its association with procreation.

As is obvious, these contending tendencies produced a certain in-built tension in the birth control movement. The movement was ultimately taken over by the neo-Malthusians by the 1920s. This is attributed partly to the period of post-First World War reaction; partly to the weaknesses of the socialist and feminist movements; and above all to the rightwing fear of communism after the establishment of the Soviet Union in 1917. This fear was strengthened in the 1930s when the Western world was threatened with crisis, the Great Depression, which the Soviet Union was seen to be able to withstand (Bondestam and Bergstrom, 1980). In the field of economics the time was ripe for the Keynesian revocation of Malthusian theories of population.

Annie Besant and Charles Bradlaugh's trial in 1877 over the publication of a book on contraception entitled *The Fruits of Philosophy* was a *cause-celèbre* to the birth control movement. Besant herself, before she got involved in the esoteric religions of Theosophy and India, published the neo-Malthusian tract entitled *The Law of Population*, carrying advice on what she called marital prudence. The notoriety of the Bradlaugh–Besant trial ended the career of the former, while Besant went on to found with C.R. Drysdale, a medical witness at the trail, the Neo-Malthusian League in 1877. The aim of the League was to:

> ... agitate for the abolition of all penalties on the public discussion of the population question and to spread among the people by all means a knowledge of the law of population of its consequences, and its bearing on human conduct and morals. (Demerath, 1976: 33)

A journal was brought out called appropriately, *The Malthusian*. Birth control propaganda was initially aimed at middle-class women who sought to limit fertility. The philosophy was that it was physically possible and morally desirable for husbands and wives to control the size of their families; and that the ultimate decision to have one or more children should be made by the couple and not by tradition, church, or state. Soon, however, the ambit was widened to include the understanding that a small number of children in a family was good for the society as a whole which would otherwise be endangered by a rapid rise of population.

Margaret Sanger, an American nurse, possibly did more than anybody else to ultimately put birth control on the world agenda. Powerful and influential, she has been described as the 'messiah of medicalised birth control'. While still involved in the feminist and socialist movements—a heritage she deeply disowned in her later years—she brought out a pamphlet entitled *Family Limitation*, in 1914. Her primary aim was to limit what she perceived as the excessive fertility of the poor, a view that caused distress and shock to her anarchist mentor Emma Goldman from whom she was subsequently estranged. 'Large families', Sanger wrote, 'are associate with poverty, toil, unemployment, drunkenness, cruelty, fighting, jails; the small ones with cleanliness, leisure, freedom, light, space, sunshine' (cited in Greer, 1984: 304). Her most famous book was the 1920 publication *Women and the New Race*, an orthodox tract of eugenics: 'First

stop the multiplication of the unfit. This appeared the most important and greatest step towards race betterment' (cited in Greer, 1984).

Even as views such as this alienated her erstwhile associates, it won favour among the rich and influential. Sanger was able, in addition, to attract attention, if not notoriety, to her cause by her unorthodox tactics. She founded the American Birth Control League in 1921, a nationwide organisation for medicalised birth control. Sanger had won over medical professionals to her cause, along with neo-Malthusians and eugenists. What distinguished Sanger's efforts from those of the feminists and socialists was the professionalisation of birth control (Gordon, 1976). In 1925, she organised the International Neo-Malthusian and Birth Control Conference in New York bringing together leading engenists and birth controllers; and in 1927 the First World Population Conference in Geneva, which brought together American and European eugenists and neo-Malthusians. In 1940, Henry Pratt Fairchild, President of the American Eugenics Society, told the annual meeting of the Birth Control Federation, the new incarnation of the American Birth Control League:

> One of the most outstanding features of the present conference is the practically universal acceptance of the fact that these two movements (viz., eugenics and birth control) have not come to such a thorough understanding and have drawn so close together as to be almost indistinguishable. (cited in ibid.: 290)

This momentous marriage had the financial backing of American corporate capital that had earlier supported eugenics: Gordon notes that 'in no academic field was the coalition between corporate capital and scholars developed more fully than in eugenics' (ibid.).

In England, meanwhile, the Ministry of Health established a National Birth Control Council in 1930; the Council became, in 1931, the National Birth Control Association. On the Birth Control Association were several neo-eugenists, prominent among them Julian Huxley and Major Darwin.

In the 1940s and 1950s, eugenic ideas were considered embarrassing, close as they were to those of the architect of the Nazi holocaust. Population control, however, came to occupy a respectable position. This was also a period for major shifts in perspective in the discipline of demography. Earlier demography was concerned with attempting to *understand* demographic phenomena. Viewing nineteenth-century

population changes, research in demography over six decades had crystallised into a Theory of Demographic Transition.

This 'theory' held that wide-ranging shifts in a large number of socio-economic variables, among others urbanisation, industrialisation, rising standards of living, the health revolution, together brought under the rubric of modernisation, had led to a decline of death rates followed, after a gap, by a decline of birth rates. That is to say, demography carried a perspective that viewed population as a dependent variable and socio-economic factors the determining independent variables. Demographers observed that the timing and extent of Western fertility decline had not been related to advances in contraceptive technology. In most countries of the West, the spread of contraceptives had occurred in a hostile environment with both governments and religious bodies being opposed to it. They had concluded, therefore, that fertility declined when the motivation to have children changed and was not strictly related to the ability to control fertility. Motivation changed in response to structural changes in the social system; in other words population was determined by socio-economic conditions (Hodgson, 1983).

The post-Second World War baby-boom knocked out some of the scientific credibility of the demographic transition theory (Hodgson, 1988). Leading demographers now focused on other problems; for example, it was pointed out that the theory was unable to explain the low birth rates in France and Bulgaria prior to industrialisation. What they also did in the process was to question the very perspective of the demographic transition theory.

Leading American demographers were now turning their attention to the non-industrial Third World. Kingsley Davis noted an alarming situation in India in his influential classic *The Population of India and Pakistan* (Davis, 1968). He observed that British colonial policy, replacing the savage rule of the natives with their penchant for 'hereditary plunder', had brought civilisation to India. As a consequence of their benevolent health policy, death rates had declined, but had not been followed by declines in the birth rates. A population problem, therefore, loomed large. The decline in death rates, Davis noted, did not depend upon general economic development in India as it did in the West. It had occurred due to the 'diffusion of death control techniques which did not depend on the diffusion of other cultural elements or basic changes in the institutions and customs of the people affected' (Davis, 1956: 314).

Davis highlighted the 'paradoxical' association of rapid population growth and continued widespread poverty, a 'grotesque' example of 'human self-frustration'. He argued that 'economic development alone cannot be counted on to save a situation over which it has so little control and by which it is itself so greatly influenced' (Davis, 1956: 318).

American economists during the 1950s, emphasised the role of capital accumulation in the development process. Underdevelopment was a condition of little capital stock in the workforce; development was a process of adding to that stock. It was self-evident to development economists that rapid population growth induced high dependency ratios in a country. This increased the need for investments in social sectors such as education and health, and thereby curtailed the capital available for more direct productive investments. A high dependency ratio also cut into the rate of saving in the economy. The country was thus caught in a vicious cycle of poverty–high population growth rates–low savings–low productivity–poverty.

Some economists developed models describing a 'low-level equilibrium trap' in which population growth precluded growth of per capita income. Coale and Hoover quantified the economics costs of continued high fertility and found it considerable (Coale and Hoover, 1958). Coale also pointed out that the post-War mortality decline, since it occurred most sharply in the younger age groups, was actually further increasing the dependency ratios. Large parts of the underdeveloped world were thus saddled with populations where for every one individual in the economically active years, there were one or more non-productive dependents. This appeared to be a 'demographic stumbling block' to economic development (Coale, 1956). Demographers and economists thus fed off each other's fears.

It was not long before demographers began to assert that something ought to be done about the population problem. Demography, then, became a policy science, shedding its social science heritage; it became, in this period, more prescriptive, more activist, less academic, less thoughtful. The earlier demographic perspective implied that motivation for curtailing family size could not exist in primarily peasant communities. But demographers now overturned nearly 60 years of research on the determinants of fertility by suggesting that fertility in agrarian societies could be lowered directly through the use of contraceptive technology. This vision of the determinants of fertility was entirely novel. Was this based on adequate empirical evidence? The fatally flawed Khanna Study (Wyon and Gordon, 1971) was one

piece of evidence, demonstrably unreliable and biased. It was more likely based on Davis assertion that in 'rural sections' of India, a woman in her 40s 'would show a modal preference for two or three living children' (Davis, 1956: 314).

There were other factors at work shaping these new trends in demography that viewed population as the independent variable and socio-economic factors as the dependent variable. It was these other factors perhaps which turned the demographic world upside down. What then were the factors that created and contoured this new demographic perspective?

The post-Second World War world was one of anti-colonial national liberation struggles. Colonialism collapsed in large parts of the globe; post-colonial nations rushed to their trysts with destiny. As these nations set out on their long delayed journey to industrialisation, they were beckoned by the Soviet model. The Soviet Union was then the prime twentieth-century example of planned and rapid industrialisation. Indeed in the early 1940s, the leading American demographer Notestein had held out the Soviet case as an exemplar of how to deal with the population problem (Notestein, cited in Hodgson, 1988).

The example of a backward nation achieving planned and rapid industrialisation was heartening to demographers who believed that industrialisation and modernisation necessarily preceded fertility decline. But when US's war ally grew to be her most feared competitor in the Cold War era, and when the Third World became the arena of this competition, such a line of thought—particularly in the paranoid McCarthy-years—was no longer possible. Population growth in the Third World countries was now a source of horror; inseparable from the probable political consequences envisioned. The establishment of a communist state in China injected a note of urgency to these worries. The ruling classes in the First World were acutely aware that the Third World was the source of raw materials that they must continue to have access to; the defection of these nations to a communist block would be a blow to their economic interests.

Kingsley Davis described the 'uncommitted' third of the world a 'prize to be won in the struggle between the Communist and the free worlds' (Davis, cited in ibid.: 549). Davis also noted:

> What the United States would like to see them (the leaders of the underdeveloped counties) do is to foster peaceful and democratic industrialisation, a rising level of living, and, in general, *adherence to*

> *our side*. To this end we have given or lent money for agriculture, industry, transportation, public health and arms. We have maintained that this is an *effective way to head off Communism* because, as we say, chronic poverty breeds Communism. This reasoning has much to commend it, but it ignores population trends and thus runs the danger of underestimating or misinterpreting the requirements for economic development. (emphasis added) (Davis, cited in Hodgson, 1988: 549)

Davis, like other Western demographers, was attempting to influence US policymakers to include population control as a component of US aid by playing on their fears of communism.

At this point demographers such as Davis, Hauser, and Tauber drew attention to the race between India and communist China, the outcome of which was thought to be of great importance to the free world. India was perceived as the last bastion of freedom; to be guarded against the communist onslaught.

One very significant, if not decisive, influence on the shape of demography and the growth of the population control lobby was the quantum and nature of funding, and the consolidation of what is now known as the population control establishment. We had earlier noted that eugenics had attracted American corporate capital. With the co-option of eugenics into the population control movement, funds began flowing, initially from the Ford Foundation and the Rockefeller Foundation, into both demography as an academic discipline and its policy counterpart, the population control lobby. Between 1952 and 1975, the Ford Foundation spent more than $150 million on population control. Of this, about $80 million went into research and training in reproductive biology. About $35 million was used to finance family-planning programmes. India received more than $20 million (Demerath, 1976).

Hodgson notes that:

> ... the expenditures on demography had a profound impact. In 1950 it was taught at the graduate level in only three places. Seven additional programmes were added between 1951 and 1961; nine more between 1961 and 1967. From 1952 to 1968 a dozen population centres in the United States were the recipients of major Ford Foundation funding. (Hodgson, 1988: 552)

In 1952, John D. Rockefeller, a major actor in the arena of population control, established the Population Council. The Population

Council stepped in to aid demography's rapid growth with its fellowship programme and institutional grants. These funds changed a small group of scholars, sharing an interest in a subject, into a substantial group of researchers attempting to resolve a crisis of their own making. The foundations also funded the establishment of population programmes in American universities with special fellowships for Third World students. These students were trained to view fertility as a variable capable of being manipulated by contraceptive technology; a variable which could be moulded into a solution to the problem of poverty in their societies. Leading Third World demographers were thus trained to imbibe and share the perception of the West about the population problem and its solutions.

As Hodgson has shown, by the early 1960s, the population control establishment has finessed a 'standard choreography' for encouraging governments in developing countries to initiate or strengthen family-planning programmes. This involved, first, the grant of fellowships by the foundations to Third-World scholars for study at various demographic centres in the West, where they would 'absorb a crisis orientation towards population growth' (Hodgson and Watkins, 1997: 481). The next step involved KAP studies which would be used to document 'an unmet need' or a ready market for birth control. Finally, technical and financial assistance from these institutions would lead to the *pas de deux*. Nobel laureates were invited to sign statements condemning the 'scourge of overpopulation' that were then presented to the UN (Chesler, 1992: 456). More widely read books, from the Population Council, were such apocalyptic neo-Malthusian tracts as Osborn's *This Crowded World* (1960) or the Ehrlichs's *The Population Bomb* (1968).

Journals dealing with demography were also funded by monopoly capital. The Population Council published *Studies in Family Planning* and *Population and Development Review*; the Ford Foundation provided the seed capital for *Demography*; and that handmaiden of US foreign policy then engaged in containing communism in Vietnam, USAID, funded the *International Family Planning Perspectives* (Hodgson, 1988). Indeed as Watkins has shown, departing from the dry arcane language of academia, a 1968 issue of *Demography*, with articles by demographers and foundation representatives, spoke in a language eerily familiar today in a post September 11 world, that of a holy war to control Third World population growth (Watkins, 1993).

India has always been at the forefront of the attention of population controllers. We had noted earlier the comments of the French priest Abbe Dubois, perceptions which deeply influenced colonial administrators. The 1891 Census Report, for example, invoked Malthus to contend that overpopulation was responsible for Indian poverty (Banerji, 1985). This was then repeated in subsequent censuses also. Patnaik points out that in the India subcontinent, population growth is a relatively recent phenomenon; it dates back to the 1920s and makes its appearance only on comparison of the censuses of 1921 and 1931. The stagnation of the economy preceded this period by decades. He points out that between approximately 1860 and 1910, the per capita income at 1948–49 prices was estimated to have increased by approximately a rupee per year (Patnaik, 1973).

Focusing on population growth as an explanation for Indian poverty is, therefore, seriously misleading. It nonetheless held great appeal to not only the colonialists but also to leading sections of the Indian population. For example, Wattal's influential work entitled *The Population Problem in India: A Census Study*, published in 1916, commences with Malthus' law of population, concluding that the 'alarming' growth of Indian population was responsible for widespread poverty and ill-health (Wattal, 1934). Mass, for instance, has noted that by the 1930s 'significant layers of the native elites adopted neo-Malthusian views' (Mass, 1974: 651). Margaret Sanger, therefore, had a ready and receptive audience.

The first family-planning clinic in India was opened in 1925 by Karve who later went on to assist in the formulation of the official policy on family planning as a member of the National Sub-Committee on Population. The Indian chapter of the neo-Malthusian League was inaugurated in Madras in 1928 (Bose and Desai, 1974). In 1930, the world's first government-sponsored birth-control clinic was inaugurated at the behest of the Maharaja of Mysore. Madras followed with the establishment of birth-control clinics in state hospitals in 1933. In 1935, the Family Hygiene Society was established in Bombay. The society brought out a journal quaintly entitled *The Journal of Marriage Hygiene*. In the same year Sanger undertook a triumphant tour across India, winning friends and influencing people, although she left Mahatma Gandhi singularly unimpressed. One such apostle, Lady Dhanvantri Rama Rao, invited her to address the All-India Women's Conference (Lakshmanna, 1988).

In 1938, Lady Rama Rao and Margaret Sanger organised the First Family Hygiene Conference in Bombay. They were assisted by an Indian millionaire whose American wife shared Sanger's conviction that India was poised at the precipice of a population explosion and had, therefore, established the Watamull Foundation to control it (Greer, 1984). Also in 1938, the Indian National Congress established a National Planning Committee under the chairmanship of Jawaharlal Nehru. The deliberations of one of the sub-committees, chaired by Radhakamal Mukherjee, were devoted to the question of population. Its concerns were largely eugenic in nature. It deplored the fact that 'attention to eugenics or race culture are matters hardly yet in the public consciousness of this country' and went on to say:

> Man, who has come to the stage of development where he is anxious to breed carefully such species of the lower animals as dogs or horses to obtain very specific qualities in particular specimens of the species, has not yet realised apparently the possibilities inherent in careful scientific breeding of the human race. (National Planning Committee, 1948: 7)

The Second World War diverted the attention of planners from such concerns. But in 1949 the Family-Planning Committee was formed in Bombay with Lady Rama Rao as its president. In 1951, it was renamed the Family Planning Association of India (FPAI). The FPAI has been a major force shaping population policy in the country. Indeed it takes credit for 'playing an active role in inducting the first Planing Commission to incorporate family planning in health' (FPAI, 1975: 1). Financial assistance to the FPAI is largely provided by international agencies, particularly the Rockefeller Foundation supported International Planned Parenthood Foundation (IPPF); in 1982 the FPAI received a project grant of US $2,782,000.

It was in this period—the 1950s—that the population control lobby was consolidated. Hugh M. Moore, an American millionaire, established the Hugh Moore Fund which published a pamphlet called *The Population Bomb* in 1954. The Ford Foundation joined the Moore Fund and the Rockefeller Foundation in their activities. In 1952, Margaret Sanger and Lady Rama Rao launched the IPPF in Bombay. One of the most influential people invited to this conference was the eugenist C.P. Blacker, who, setting the agenda noted:

> Nor need we question that a husband and wife living in squalor and ignorance who already have a large number of children not being reared properly might well be considered unfit to have additional children. Yet many parents of these various unfit types keep producing unduly large numbers of children, chiefly because through ignorance or indifference—and often against their will—they let Nature take its course. To combat this situation, eugenists favour the spread of birth control. (cited in Greer, 1984: 341)

The IPPF has been a major force in the population control movement across the globe. The funding for the IPPF initially came from the Hugh Moore Fund and the Rockefeller Foundation. Soon it attracted funding from Du Pont Chemicals, Standard Oil, and Shell. On the board of IPPF sit representatives of Du Pont, US Sugar Corporation, General Motors, Chase Manhattan Bank, Newmont Mining, International Nickel, Marconi RCA, Xerox, and Gulf Oil, a veritable who's who of America's corporate and finance capital.

The Rockefeller Foundation and The Milbank Memorial Fund founded an Office of Population Research at Princeton University. The office included leading demographers such as Kingsley Davis and Frank Notestein. When Rockefeller founded The Population Council both these demographers took up employment there (Gordon, 1976). Hugh Moore founded the World Population Emergency Campaign in 1960 with funds from his foundation and from Du Pont. The president of the World Bank ran the campaign. The primary aim of the World Population Emergency Campaign was to create and reinforce First World fears of a population 'explosion' in Third World countries with dire consequences for the entire globe (George, 1976). It has been suggested that the revolution in Cuba provided additional impetus to these fears (Mass, 1974). The World Population Emergency Campaign and the Population Council began a systematic and powerful campaign to influence US policymakers to include population control as a component of US aid to Third World countries.

One singularly successful method to do this was to induce hysterical fear, if not paranoia. Hugh Moore was an expert at this: he had successfully sold disposable paper cups for the Dixie Cup Corporation by peddling false ideas about the spread of tuberculosis by drinking from glass cups in public places. He argued that the 'population bomb threatens to create an explosion as disruptive and dangerous

as an explosion of the atom, and with as much influence on prospects for progress or disaster, war or peace' (cited in Hartman, 1987: 103).

Not only were hundreds of thousands of copies of T.O. Greissimer's *The Population Bomb*, a 1954 avatar of Ehrlichs's bestselling book, distributed, there were also advertisements placed in all leading newspapers and television channels. One went:

> A world of mass starvation in underdeveloped countries will be a world of chaos, riots and war. And a perfect breeding ground for communism .... We cannot afford a half dozen Vietnams, or even one more .... Our own national interest demands that we go all out to help the underdeveloped countries control their populations. (cited in Hartmann, 1995: 106)

This campaign bore fruit in 1966 when President Lyndon Johnson included a commitment of federal funding for population control. The President observed: 'Let us act on the fact that less than five dollars invested in population control is worth a hundred dollars invested in economic growth' (Mass, 1974: 665). John D. Rockefeller emphasised the limitations of private efforts at population control hitherto employed and called for greater governmental participation: 'The problems of population are so great, so important, so ramified and so immediate that only government, supported and inspired by private initiative, can attack them on the scale required' (Doyal and Pennel, 1981: 280).

In other words, two developments followed the grant of government support for population control: first, the amount of funds available increased enormously and second, the private foundations shifted some of the costs to the American tax-payer who had, by now, been convinced that the population growth rate in the Third World countries was a threat to the stability of the world. The US government now began to expend massive funds on population control. Expenditure increased from $4.6 million in 1965 to $14.7 million in 1969; USAID funding increased from $10.5 million in 1965 to $45.5 million in 1969 and $123 million by 1972 (Caldwell and Caldwell, 1986).

Given the debacle in Vietnam, the Secretary of State, Henry Kissinger directed the US National Security Council to examine the 'implications of worldwide population growth for U.S. security and overseas interests' (cited in Hodgson and Watkins, 1997: 486). The

Council's secret National Security Study Memorandum was to address, among other issues, the following:

(*a*) the consequences of population growth for demand of US exports, especially of food, and the trade problems the US may face from competition for scarce resources; and
(*b*) the likelihood that population growth would produce disruptive, indeed dangerous imbalances in foreign policy matters and prove a threat to international stability.[17]

The NSC Study Memorandum 2000 found that rapid population growth fostered political instability and identified countries of 'special U.S. political and strategic interests', India being one of them, where population stabilisation policies needed to be pursued by the US. The Memorandum, however, suggested discretion while doing so:

> The U.S. can help to minimize charges of an imperialist motivation behind its support of population activities by repeatedly asserting that such support derives from a concern with: (a) the right of the individual couple to determine freely and responsibly their number and spacing of children ... and (b) the fundamental social and economic development of poor countries. (cited in Hodgson and Watkins, 1997: 486)

At the same time, changes in American policy began to exert an influence on the UN. By the late 1960s, a number of UN and multinational agencies, including the UNFPA and the World Bank, were involved in population control programmes in Third World countries. The President of the World Bank, Robert McNamara explained:

> My responsibility as president of the World Bank compels me to be candid. Are we to solve this problem by famine? Are we to solve it by riot, by insurrection, by the violence that desperately starving men can be driven to? (cited in Mass, 1974: 570)

The World Bank officially stated:

> All such activity arises out of the concern of the Bank for the way in which the rapid growth of population has become a major obstacle to social and economic development in many of our member states. Family planning programmes are less costly than conventional development projects. (ibid.)

Neo-Malthusianism had thus arrived on the world agenda. Inevitably, India—always at the forefront of the family-planning movement's field of vision—saw neo-Malthusianism thrust forcefully on its official policy and programmes. They not only funded research but were also involved in training demographers, doctors, and statisticians. It is not surprising then that large and influential sections of Indians fervently uphold these neo-Malthusian ideas. We shall now very briefly examine what the conceptual, methodological, and empirical problems with neo-Malthusianism are.

We had earlier noted that in terms of methodology, neo-Malthusianism and Malthusianism are not distinct. The earlier critique of Malthusian methodology, therefore, applies equally to neo-Malthusianism. The critique, in short, is that it misses the wood for the trees. It focuses on a part of the larger picture, misjudges association for cause, provides misleading and partial explanations, and is based entirely on the validity of the assumptions made. Hodgson, for example, notes that when the 'catastrophe' predicted by neo-Malthusian 'orthodox demographers' never arrived, their assumptions were subject to scrutiny, with startling results (Hodgson, 1988). Coale's model had measured the costs of high dependency ratios and had found them considerable. But Paul Schultz found no clear relationship between the percentage of gross national product (GNP) invested in education and the age structure of the population (Schultz, cited in ibid.).

Demographers assumed that high fertility would produce low rates of saving but Kelley (1973) found the actual relationship more complicated. Mason (1988) confirmed Kelley's findings that children were not just a short-term source of expenditure for parents; they could often be a long-term form of 'risk protection' (Cain, 1983), or even a kind of savings.

One important underpinning of the neo-Malthusian argument is that population growth eats into resources which are finite. That some resources are limited is a truism. But what the more general and abstract statement here does is gloss over the actual picture of who is actually consuming the resources. Social problems—of poverty and hunger—are attributed to that part of the population that is said to grow the fastest. But this is precisely the population that consumes the least, totally as well as per capita. This is true from both national and international perspectives.

It is argued for instance that a reduced population will *ceteris paribus* lead to reduced energy consumption, less resource use and

less pollution. This is strictly true in *ceteris paribus* arguments alone; *ceteris paribus* cannot be used in reality. In reality, according to UN sources, consumption of energy in coal equivalents in 1975 amounted to 10,999 kg per capita per annum in the US; and to 221 kg in India per capita per annum (Hofsen, 1980). The prevention then of one American birth is as important as the birth of 50 Indians in terms of energy use. Yet population controllers worry about the growth of the Indian population.

The over-population argument also elides the fact that there occurs a net transfer—according to a very conservative estimate—of close to $200–250 billion annually from the countries of the South to those of the North. Indeed this figure has increased substantially over the last three decades. Since 1980, the periphery has transferred to the centre about $3,450 billions. During this period, marked by the demise of actually existing socialism and of Keynesianism, along with the rise of the neo-liberal policies of Reagan and Thatcher, inequalities within and between countries have risen sharply: the income gap between the world's richest and poorest has more than doubled. In 1960, the poorest 20 per cent of the global population received 2.3 per cent of the global income. By 1991, their share had sunk to 1.4 per cent. Today, the poorest 20 per cent receive only 1.1 per cent of global income. The ratio of the income of the wealthiest 20 per cent of the people to that of the poorest 20 per cent was 30 to 1 in 1960. By 1995, that ratio stood at 82 to 1. This is based on distribution between rich and poor countries, but when the maldistribution of income within countries is taken into account, the richest 20 per cent of the world's people in 1990 got at least 150 times more than the poorest 20 per cent (United Nations Development Programme [UNDP], 1992). The 20 per cent of the world's people who live in the highest income countries account for 86 per cent of the global consumption; the poorest 20 per cent, only 1.3 per cent.

Population growth in the periphery is a drop in the ocean compared to the consumption of the populations of rich nations. Neo-Malthusian views focusing on birth rates in the periphery obscure this critical issue. In other words, neo-Malthusian economists are barking up the wrong tree: what should be looked at is not just population, but effective population, which is a function of numbers and their consumption. But they nevertheless do serve a crucial function; they divert attention from the fact that resources are being exploited

in the Third World by First World nations and that there is a net transfer of resources from the developing world to the industrialised world. This does not occur naturally, fortuitously or automatically; it is the product of social, economic, and political institutions, both in the First World and in the developing world. In other words, the ruling classes in the Third World are part and parcel of this arrangement of the utilisation of resources.

If we consider intra-national figures in India, for instance, the figures are equally startling. The bottom 20 per cent of the population has a share of about 8 per cent in total consumption expenditure in the rural sector and about 7 per cent in the urban sector; while the top 20 per cent has a share of about 39 per cent in the rural sector and 42 per cent in the urban sector (Bardhan, 1974). It is simply not true that the poor are consuming resources disproportionately. What the data also indicates is that by cutting down the numbers in the lower decile groups, which is the avowed objective of population control, the quantum of resources generated would be minuscule. The inescapable conclusion is that population control is not even an efficient or effective way of raising resources. There are more effective ways to raise these resources, even within the same socio-political set-up.

Demographic trends in the developing countries have quite clearly revealed the conceptual and empirical weaknesses of neo-Malthusianism. Bauer observed:

> Both economic history and the contemporary scene make clear that the conventional reasoning fails to identify the principal factors behind economic achievement. Rapid population growth has not inhibited economic progress either in the west or in the contemporary Third World. The population of the western world has more than quadrupled since the middle of the 18th century. Real income per head is estimated to have increased by the factor of five. Most of the increase of incomes took place when population increased as fast, or faster than in most of the contemporary less developed world. Similarly, in what is now called the Third World, population growth has often gone hand in hand with rapid material advance. (Bauer, 1984: 20)

Simon (1984) called attention to the large body of scientific work showing an absence of the supposed negative relationship between population growth and economic growth in the long run.

And the effect of higher population density actually seems to be positive.

In the same vein, Preston, observing the association of rapid population growth accompanying increasing rates of per capita income growth in large parts of the developing world, concludes that 'rapid population growth in most times and places is a relatively minor factor in reducing per capita income and other measures of welfare' (Preston, 1984: 10). Indeed it has been suggested on the basis of empirical evidence that population growth may, in fact, be desirable as it appears to accelerate technical change and innovation (Boserup, 1981). Covering a broad historical sweep of the entire world, Diamond comes to similar conclusions (Diamond, 1999).

The near-zero correlation between population growth and per capita economic growth in the Third World, which became apparent in the 1970s and the 1980s, had, in fact, been noted 20 years earlier by Kuznets (1967) and Easterlin (1967). But in the full tide of neo-Malthusianism this had been largely ignored.

Anthropologists and sociologists, meanwhile, also pointed out the gross limitations of a neo-Malthusain understanding of the population question. Caldwell concluded that the most critical factor was the motivation to bear children. In most primarily agricultural societies, this motivation—moulded by social-structural factors—was limited (Caldwell and Caldwell, 1986). Mamdani carried out a brilliant critique of the neo-Malthusian Khanna Study. He not only drew attention to the conceptual and methodological weaknesses of this very influential study but hinted at, with evidence, fraudulence. He showed that despite evidence to the contrary the study had come to pre-determined conclusions. In other words, neo-Malthusianism had proven to be a theoretical red herring. His study of India unearthed evidence that people are not poor because they have large families but on the contrary they require large families because they are poor. The poor peasant's decision not to accept contraception was a rational one for that would be 'courting economic disaster' (Mamdani, 1973: 144).

Djurfeldt and Lindberg furnished data questioning the belief in the high fertility of marginalised peasants. They too highlighted the economic and social need for children in such groups in a marginalised peasant economy (Djurfeldt and Lindberg, 1980). George (1979), Zurbrigg (1984), and Meillasoux (1974: 106) reached similar conclusions.

In addition, for a variety of reason, support to demography and to population control, were withdrawn during this period. The stock market collapse of the early 1970s had apparently dramatically altered financial support. Further, there was a consolidation of right wing forces during this period as exemplified by the election of Ronald Reagan as president. There was, therefore, a withdrawal of both government and private foundation funding to population control, especially since they were associated with abortion. Financially lean but academically more fit, demography became once again, a more reflective sciences in the US. Demographers began to disown the heritage of Davis and Notestein—who increasingly came in for attack from feminists who labelled them eugenic demographers.

But facts, in this case, are not enough; their existence has not laid to rest the shadow of neo-Malthusianism in practice. The same familiar ideas of neo-Malthusianism enfold, like a shroud, both discourse and policy of family planning in India.

Neo-Malthusianism fails to recognise that motivation to practise family planning is dependent on the socio-economic situation of parents, which in turn alters the determinants of family size. It also fails to recognise that these determinants vary among different sections of the population. In other words, birth rates do not possess geographical or national characteristics; they are determined or moulded by the behaviour of the determinants of family size, which vary among different sections of the population, depending on socio-economic factors. The family-planning programme in India, which fails to recognise this fact, seems doomed not to learn its lessons from history.

Malthusianism and neo-Malthusianism offer an excessively simplistic, but appealing, understanding of the complex relationship of resources and population an understanding which has proven to be a theoretical red herring. Despite their flimsy conceptual, methodological, and empirical foundations, these theories have won widespread acceptance in both academic and public policy circles. This acceptance is explained by factors both manifold and complex, some of which have been discussed here. The problems faced by the Indian family-planning programme are thus not solely technical, administrative, or strategical. The neo-Malthusian understanding of the population issue lies at the heart of the programme's failure to understand the issue differently.

NOTES

1. Note, for example, the monumentally scholarly work of Cassen (1980).
2. Malthus acknowledged Steuart in the second edition of *An Essay on the Principle of Population and a Summary View of the Principle of Population.* But the acknowledgement is, in a sense, superfluous. Even a casual reading of his text reveals striking similarities of idiom and metaphor; that of the tree is merely an example.
3. The latter, in fact, effectively undermines one of Malthus's fundamental laws regarding the inevitable consequences of the passion between the sexes.
4. This argument is, of course, extremely familiar, and is at the heart of neo-liberal economic policies. Such arguments by, among others, Reaganites and Thatcherites over the last two decades, have been advanced to dismantle welfare provisions for the poor.
5. The shadow of Malthus, as we noted earlier, fell heavily on the deliberations of the Bhore Committee. The Bhore Committee used exactly these arguments for family planning in India.
6. The tale of Robin Hood and his merry men, robbing the rich to give to the poor, is the mythological account of this process of the immiserisation of a section of the population in the wake of the commercialisation of agriculture.
7. Hobsbawm tells us the labourer in the work-house 'had to separate from wife and child in order to dicourage the sentimental and unmalthusian habit of thoughtless procreation' (Hobsbawm, 1977: 66) and that the Poor Law was indeed designed to make life so miserable for the rural paupers as to force them to migrate to any job that was offered. No better description of the work-houses is available than that in Dicken's novels.
8. Condorcet was the Marquis de Condorcet. His famous work was the *Esquisse d'un Tableau Historique des Progres de l'Espirit Humain,* roughly translatable as the 'Sketch of the Historical Tableau of the Progress of the Human Spirit', published in French in 1794 and in English the following year. He was an active participant in the French Revolution of 1789. In this book he outlined 10 stages of human civilisation where the last stage was the universal brotherhood of all the people of the world, liberated from inequalities of race, gender, and class. William Godwin was the influential father-in-law of the poet Shelley. His book *Enquiry Concerning Political Justice* was published in 1793, with second and third editions in 1796 and 1798. Daniel Malthus, father of Thomas Malthus, was deeply enchanted with these visionary works which he urged his more conservative son to read. Malthus wrote the *Essay* as a rejoinder.
9. Hobsbawm writes wryly of this period: 'There was an order in the universe, but it was no longer the order of the past. There was only one God, whose name was steam and spoke in the voice of Maithus, McCullough, and anyone who employed machinery' (Hobsbawm, 1977: 229).
10. William Wordsworth, before he turned reactionary, on a walk with a friend encountered a hungry peasant girl. Moved, he wrote:

    And at that sight my friend
    In agitation said, 'Tis against *that*

That we are fighting,' I with him believed,
That a benignant spirit was abroad,
Which might not be withstood, that poverty,
Abject as this would in a little time
Be found no more, that we should see the earth
Unthwarted in her wish to recompense,
The meek, the lowly, the patient child of toil,
All institutions for ever blotted out,
That legalized exclusion, empty pomp,
Abolished, sensual state and cruel power,
Whether by edict of the one or few;
And finally, as sum and crown of all,
Should see the people having a strong hand
In framing their own laws;
Whence better days
To all Mankind.

Wordsworth was of course recalling the glory and the hope aroused by the French Revolution.

11. This 'law' asserts that if production is carried out with different factors of production, and if some of these factors are constant in amount, then an increase in the other factors will increase production although not proportionately.
12. Abbe Dubois, a Catholic priest, escaping the anti-clerical blood purges in the aftermath of the French Revolution travelled extensively through south India. His journals were purchased by the East India Company to better understand the creatures they were ruling.
13. Tender-hearted social workers who might well wince at the crudity of this statement may note the views of Tara Ali Baig, head of the Indian delegation to the 1974 UN Population Conference at Bucharest and the Chairperson of the Indian Council of Child Welfare. 'Sterilization of one partner', she said, 'has to be made imperative where a man or woman suffers from hereditary insanity, feeblemindedness or congenital venereal disease: they must be barred by law from procreating children. This should have been done decades ago. If children's lives and future are to be protected, compulsory sterilization is necessary for many reasons .... After all considering the crime against children committed by irresponsible parenthood, compulsory sterilization is hardly punitive. Sterilization of the unfit is long overdue.' Greer, not incorrectly, cites this as a typical upper-class (and upper-caste) reaction of revulsion for the poor and disadvantaged (cited in Greer, 1984: 360).
14. This continues to have enormous appeal today in our country, as the spate of 'disincentives' in the family-planning programme, would attest.
15. Had these immigration laws not been tightened for eugenic reasons, a large number of Jews in Germany and Poland might perhaps have escaped the death camps.
16. Such laws for eugenic sterilisations were enacted, other than in the USA, in Canada and in the Scandinavian countries. A few years back a woman sterilised in childhood because her parents who had abandoned her in a home were alcoholics, brought a class action suit against the Canadian Government. The Supreme Court of Canada

dismissed her suit arguing that she had been sterilised in her best interest according to the scientific understanding that then prevailed.

17. This document, now declassified, is available at the website: *www.lifesite.net/waronfamily/nssm200/nssm/200.pdf*

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3

BEYOND MALTHUSIAN ARITHMETIC

Could men but come awake—enchantments keep
Their noblest faculties held fast in sleep
And frightful dreams and real fears, alas!
Before their soggy haunted vision pass
Not least the reverend Thomas Malthus with his trick
Of killing conscience with arithmetic.

James MacAullay

Malthusian fears generate Malthusian arithmetic. Beginning in the late 1950s and early 1960s, a large number of factors—among them the quantum and nature of funding—together gave shape to, and contoured, a particular understanding of the population resource question. These factors also coloured the research that was undertaken along with the launch of population control programmes in much of the Third World countries. One factor was undoubtedly the short historical memories as academics, in particular demographers, pressed the panic button in response to what came to be increasingly described as the 'population explosion' or the 'population bomb' in Third World countries.

Sen, for instance, noted:

> During the nineteenth century while the inhabitants of Asia and Africa grew by 4 per cent per decade or less, the population of the area of European settlements grew by around 10 per cent every decade. Today the combined share of Asia and Africa (71.2 per cent) is considerably below what its share was in 1650 or 1750 AD. If the United Nations prediction that this share will rise to 78.5 per cent by 2050 AD comes true, then the Asians and Africans would return being proportionately almost exactly as numerous as they were before the European industrial

> revolution. There is, of course, nothing sacrosanct about the distribution of population in the past, but the sense of growing 'imbalance' in the world, based only on recent trends, ignores history and implicitly presumes that the expansion of Europeans earlier was natural, whereas the same process happening now to other populations unnaturally disturbs the balance. (Sen, 1994a: 16)

It was also related to the consolidation of the population control establishment and, above all, Cold War political concerns, tinged undoubtedly with racism (Ross, 1998), that we saw in the last chapter. Together they contributed to a spate of studies with an explicit neo-Malthusian understanding of the population question. One of the most influential was, of course, the Khanna Study, funded, among others by the Rockefeller Foundation. It might be useful to lavish some attention on this study simply because it was so monumentally influential on policy. It set the trend for other similar studies and went on to influence the structure of the family-planning programme.

A review of all the studies in the field of family planning would not only be an impossibly daunting task, but in a sense may also be quite unnecessary since they have been overwhelmingly dominated by studies with a neo-Malthusian understanding of the issue. Such studies are also self-validating, proving what they set out to prove, their assumptions leading axiomatically to certain conclusions. This is indeed a field where the aphorism that the eye does not see what the mind does not know holds with such poignant consequences. It is not that the studies were deliberately geared towards policy implications, nor that they were primarily ideologically motivated, it was just that given the overwhelming *zeitgeist* and the nature of the studies—ahistorical, seldom asking the questions differently—they came to assume a certain pattern revealing that the 'poor' had too many children. From this it followed, rather peculiarly, that poverty was a result of overpopulation.

One major and fundamental problem, either explicit or implicit, is that in a substantial number of studies, the study populations are assumed to be homogenous. That is to say, not enough attention is paid to issues of socio-economic differentiation within the population although it is socio-economic events which contour and indeed determine demographic events. That the basic economic considerations in relation to fertility—and therefore responses to family planning—could be totally different among different segments of the population is,

therefore, not appreciated (Nadkarni, 1976). To illustrate, in Rao's excellent bibliography of 550 studies on family planning in India, only a minuscule number (11) are *informed* of the importance of social differences in fertility (Rao, 1974). Of these 11 studies, the majority use caste or education as the basis of stratification. While they do indeed have some merit, these criteria also have obvious limitations as they are themselves dependent upon income and class. So dismal is the situation that after reviewing research studies in family planning, Krishnamurthy wonders if there are significant differences in fertility between social classes in India (Krishnamurthy, 1968).

This is truly surprising for historical material is overwhelming with data and explanations for fertility differentials between different social groups. One of the first such studies was that by the French civil servant, Arsene Dumont, in the late eighteenth century, which dismally contemplated the decline of the population of France and in consequence her importance in international affairs in comparison with England, which was, at that time, experiencing a huge surge in its population (Clark, 1968). Dumont, noticing widespread differences in fertility between different social groups, attributed them to what he called *la capillaire sociale*. Taking an analogy from the biological sciences, he felt that fertility responded much as capillary action did, with the liquid rising narrowly in a pipette. Thus the fundamental observation that the propertied groups, in order to rise socially and to enable their children to do so, tended to have fewer children. Peasant families on the other hand, not only lacked these negative inducements against children but felt a positive inducement for them: a child who had reached the age of seven or eight contributed to farm work, a value outweighing the cost associated with his or her upbringing.

Sen argues that Malthusian pessimism takes attention away from investigating what prompts people to make the fertility decisions they make and how these choices depend on a large number of material and other conditions within which they live and work (Sen, 1994b). Indeed Alfred Marshall had provided remarkable insights into this phenomenon, noting the strong economic roots for differentials in fertility. Marshall pointed out that different occupational groups within the labouring classes differed markedly in their fertility behaviour. He noted, for example, that the fertility of colonial settler populations—with an unending land frontier in the New West—was much higher than that of similar agrarian populations in Europe. He noted

that the average age of marriage was lowest among unskilled labourers, higher among artisans, and highest among the middle classes, and associated this to the patterns of income earnings over their life-cycles and the differential costs incurred in raising children. He observed that industrialisation had brought in its wake differentiation between skilled and unskilled labour and, echoing Dumont, he felt that people with skilled occupations restrict their fertility to be able to provide their children a better education. Finally, he also pointed out that widening margins between skilled and unskilled labour would lead to an increase in the supply of skilled labour, one factor in the declining birth rates in developed countries (Wuyts, 1998). Here lie the roots of the 'labour theory' of fertility.

Even where there is the awareness of the critical importance of socio-economic differences in fertility and mortality, all too often incomes have been used as a criterion for stratification. Krishnaji has drawn attention to the profound methodological problem that inhere in such studies. He argues that economics relies exclusively on income irrespective of how it is earned. Differences between households earning income from wages and those from cultivation or rent or trade do not matter to a ranking of families according to a vaguely conceptualised standard of living. Per capita income is thus fetishised in economic statistics. As a consequence, data gathering methods ensure that it can be measured in some way or the other, and are so displayed that all other features which distinguish families, including, of course, those with a profound demographic consequences, are lost sight of. For instance, studies that seek to study differentials in fertility in relation to per capita expenditures. He argues that the inferences are invalid since per capita expenditure is not suitable for demographic analysis. He observes:

> Demographic profiles of families are determined only in the long period—over which per capita income and expenditure is highly unstable. Per capita incomes from families can change not only from year to year but even within a year as a result of births, deaths, migration and marriage—demographic events for which precisely an explanation is being sought. These changes produce very serious biases especially when demographic parameters are estimated on the basis of a year's data. A birth reduces the per capita income of a family (by a very significant proportion if the family is small) and this alone can introduce a spurious correlation between low incomes and high fertilities derived from short-period data. Long-period fertility measures such as the number of children

> produced by a woman over her entire reproductive period cannot, on the other hand, be related to per capita income, for it is difficult to define and measure long-term per capita income for a given family. (Krishnaji, 1983: 866)

Similarly, Clark draws attention to a misleading method very commonly utilised by demographers attempting to study the links between income and fertility. This was to compare the sizes of families in the richer and poorer areas of cities, between which wide differences were found. It took some time for demographers to understand, he notes, how biased this method was: for two families with a given income, families with no children were much more likely than families with children to take up residence in a more expensive part of town (Clark, 1968). Furthermore, when income data has not been cross-classified with data on occupation, education, and so on, there are even more problems, namely, imputing to income the causation of the differences which have arisen because of other variables associated with incomes.

Krishnaji thus emphasises the need to study populations on the basis of class. This is particularly true of agrarian families where the class status of a family remains fairly, if not absolutely, stable. Analytical frameworks, he concludes, set out wholly in unidimensional economic terms, do not reveal much; indeed as we have seen, they might reveal reverse causation.

Another major problem with the plethora of studies is that they tell us about certain associations, ignoring other factors that are equally significant—the point made earlier about cross-classification. This leads to a certain fractured vision of reality, which are utterly unholistic and, at the same time, leads to spurious associations. Thus we have studies about, for example, fertility in relation to occupation, or fertility in relation to landholding, or fertility in relation to education, or fertility in relation to age at marriage and so on. We also have studies on infant mortality in relation to all these variables, namely occupation, landholding, education, age at marriage, and income. We might well have KAP studies in relation to these same variables. What would not be available is how these variables are themselves inter-related and how these impinge on and influence fertility in discrete sections of the population.

Interestingly a leading eugenist, a follower of Galton, and one of the first to study the 'inheritability' of intelligence, Arthur Pearson,

had noted the need to investigate the economic need for children in different social groups. His purpose was, of course, to bemoan the lack of reproduction among the rich, leading to the degeneration of the race and the nation. Children, he noted, were never an economic asset for the 'cultured classes', but a luxury to be paid for. As a result, these classes indulged in neo-Malthusianism, that is, birth control, successfully, while also successfully depriving the nation of brains. But, he noted, children were an economic asset for the working classes till the passage of the Factory Act, which prohibited child labour and, in effect, transformed children into economic liabilities for this class too (Kevles, 2001).

Historical data from across the world suggests that before the onset of demographic transition, family size and wealth are directly associated. It is beyond doubt that the norm was that wealthy land-holding families had large families while the poor labouring ones had relatively small ones. But historical data also suggests that as a country undergoes demographic transition, initially the fall in fertility is deepest among the propertied groups. After a period, the fall in fertility spreads to the rest of the society and in vast number of cases, reverses after a period of time. In other words, that differentials are such a given, so pervasive, and yet changing.

Data from a special census survey in Sweden in 1935 on fertility in relation to income, occupation, and education revealed this quite clearly (Clark, 1968). Occupation and education being held constant, there was a strong negative relationship between income and reproductivity in the generation that got married between 1901–15. This relationship had largely disappeared in the generation that got married between 1921–25. In the younger generation, the negative relationship was found to persist, but only among manual workers. Among salary earners, farmers and business proprietors, however, the negative relationship had disappeared and was beginning to be replaced by a positive relationship, that is, the higher the income, the more number of children. The highly paid manual worker in Sweden tended to have a smaller family than the salaried worker or businessman with the same income.

Clark thus concluded:

> Since the Swedish study, more and more evidence ... has been accumulating which points in the same direction. Perhaps it will appear to our successors that the period of declining fertility, which began

> about 1780 in France, spread over all of Western Europe, and North America in the nineteenth century, and was reversed about the 1940s, was no more than a temporary period during which the normal differential reproductivities were reversed, while both before and after this period *it was normal for wealthier and better educated families to be more, not less reproductive than their neighbours.* (emphasis added) (Clark, 1968: 183)

A special survey in the census of New Zealand in 1936 found a similar pattern. Clark provides data from studies conducted in Sicily in an earlier period, China in the 1930s, and in Punjab in 1934–35. All these indicated a trend observed in the Swedish study—that of a positive income–fertility relationship emerging after a period of time among the propertied. In the Punjab study, the differentials in fertility were accentuated by differential rates of survival. Thus agriculturists with an income of less than Rs 200 per year had 3.24 surviving children, those with Rs 200–400 per year had 3.48 surviving children, while those with over Rs 400 per year had 3.7 surviving children (Punjab Board of Economic Enquiry, 1957: 184, cited in Clark, 1968). Data from a study in Poland found that in the eighteenth century, villages with more land per head had higher fertility levels than those with less land per head, but that these differences between villages disappeared in 1931. Within any village, however, there was a strong positive relationship between income and fertility. The data covers mothers born between 1855 and 1929, arranged in three groups, which shows the reversal of poor–rich differences during 1915–29. Yet another study in Japan carried out in the 1950s divided peasants into upper, middle, and lower classes. Total fertilities were found to be 6.3, 5.3, and 5.0 respectively. A study in the Philippines found a curvilinear relationship: fertility increasing as we move up the class hierarchy, then declines in the highest category (Clark, 1968).

Why then, in spite of such studies, do we have a flood of studies in family planning that seem to imbue fertility with little social characteristics, studies which singularly fail to recognise that health and population do not merely have geographical characteristics? Why do we have the problems with the data generated that we do? Patnaik argues that this problem is common to the social sciences in general, concluding that in spite of the masses of data regularly generated, we can conclude little about the characteristics of specific groups in the population.

> To give an analogy from the natural sciences: suppose we are studying the population of all mammals. We collect information on the physical characteristics of a sample of mammals, such as their weight, height, hairiness, etc. We then proceed to tabulate the weight data by weight groups, the height data by height groups, and so on. In other words, each characteristic is treated in isolation from others. At the end of it all, we are in no position to distinguish by its special characteristics the class (species) of elephant from the class of mice even though we have all the relevant data. (Patnaik, 1987: 75–76)

Nadkarni draws attention to some other factors: that arithmetic truisms are often seen as pregnant with theory when population is concerned. His study also revealed that the poor households, primarily comprising landless labourers and poor peasants, had a smaller family size when compared to the larger cultivating households. Among the better-off sections of the village, only those in regular service employment tended to have smaller families. Cultivators tend to have larger famines than non-cultivators, but among cultivators, the size of the family among the poor is smaller (Nadkarni, 1976). He argues that the proponents of the overpopulation thesis generally stress the fact that the overpopulation of the poor is relative to their resources as an explanation of poverty. What these proponents will not say is that a household is poor because it has little control over productive resources. What they thus say is that it is poor because relative to the resources it owns, it has too many people. Thus even a single-member household of a beggar is overpopulated by this logic!

Many of the features of Malthusian arithmetic can perhaps become explicable on considering the Khanna Study. There can be no better critique of the ideology and methodology of this fearfully influential study than Mamdani's pioneering work (Mamdani, 1972).[1] One important point that he underlines is the study's conceptualisation of the problem. 'The study', he points out

> ... was plagued very little by the sort of 'cultural' misunderstanding that it had feared in the earlier stages. What *did* plague them was the directors' basic perception of the problem. To them, overpopulation was a disease ... to be treated with the techniques of an epidemiologist. (Mamdani, 1972: 37)

Gordon and Wyon, the authors of the Khanna Study felt that 'Overpopulation is a malady of society that produces wasted bodies,

minds and spirits just as surely as other familiar scourges—leprosy, tuberculosis, cancer' (Wyon and Gordon, 1971: 21). This perception of the problem, argues Mamdani, was an analytical tool for misunderstanding. Mamdani points out that this view was not confined to the study directors alone, but shared by the middle class, educated, urban, Indian staff of the study. What plagued the study then was a profound class bias. What then transpired would have been absurd, had it not been tragic: the study populations' perception of the problem was entirely different, but that the study itself was incapable of either understanding this perception or the reasons that gave rise to them. Thus when the study population seemed unreceptive to the idea of family planning proposed by the study, it never occurred to the study directors that there might possibly be something wrong with the hypothesis of the study. Instead the study design was altered on the assumption that the villagers were ignorant and did not know what was in their own best interest, and therefore required to be 'educated'. The changed study design made no difference to the study results. Although the study was a failure, Mamdani argues that the authors had too much at stake to take cognisance of this. Instead, they came to the racist conclusion that 'Westerners have strong feelings about the value of persons and of human life not shared by Punjabi villagers' (ibid.).

Looking back at the study today the authors can perhaps be forgiven for an utterly Orientalist perception of village India since the study was, in fact, a pioneering study. Yet it is striking that they build on the trope of an unchanging, static, strangely irrational people, with caste as the central ordering principle of Indian life. The study design basically comprised three study areas—one study population and two control populations. The study populations were to be served by a resident staff to make monthly household visits to acquaint each family in the sample with the advantages of family planning and to supply the necessary material. One of the control areas was used to measure the influence of data collection while the other was used to obtain data on births and deaths. Prior to commencing the study proper, an exploratory study was carried out in another village to test methods, to train staff, and to find out which of the several methods of contraception offered was most acceptable. Participant observation was claimed to be the standard method of field-work in this phase of the study although it explored sexual and contraceptive practices. The curious feature of this exploratory study was that finally only

15 per cent of the villagers accepted the contraceptives offered and yet the authors claimed that 'the people had proved highly cooperative', signalling the commencement of the definitive study.

The study villages were offered vaginal foam tablets, in addition to information and education, although strangely the efficacy of this method was not discussed. The definitive study lasted four years from 1956–60. For most of the first year, acceptance of contraception approximated the expected 25 per cent of all eligible couples. Towards the end of 1957, acceptance rates declined and never subsequently reached a figure that could have made a difference in the birth rates. Indeed the authors seemed aware of this, as they noted that: 'without a substantial improvement in this [acceptance] rate, the promise of a significant change in birth rates was poor' (Wyon and Gordon, 1971: 47). What is also interesting is that the authors themselves noted 'From 1885–1931, the registered birth rates of the district varied between 40–45 per year. They had declined by 1961 to 36' (ibid.: 60). In other words, there was a secular decline in the study area as a whole. It would thus be entirely illegitimate to attribute the noted decline to the study intervention, which is what the study authors proceed to do.

The authors' claims of having a representative population were in no manner substantiated by social, economic, or indeed even demographic data. The criterion of representativeness was that the population was rural and 'that they were aggregates of people with long-standing social relations' (ibid.: 10). But, in fact, the study villages were not representative of Ludhiana district, leave alone Punjab or the rest of India. To cite just a few of the criteria provided by the study itself, the landholding patterns, the population density, the age at marriage, the sex ratio, and the pace of emigration distinguished the study village from the rest of the district. Nor did the authors provide data on the comparability of the study population and the control population. The data provided reveals that they were not, in fact, comparable. The Control Population A differed from the study population in greater population density, in having a lower proportion of men working in agriculture, and a higher level of education. Control A also had a higher age at marriage and a lower proportion of married men. Death rates in the control area were also lower. More significantly, to quote Mamdani, 'the social structure of Manupur [the area of the Khanna Study] was radically different from that in most of contemporary rural India'. Indeed the study did not

state the criteria for the selection of the study tehsils although it did state that 'the study populations were representative of rural areas of tehsil Ludhiana and Samrala, of district Ludhiana, and to a considerable extent, of the Punjab State. The rural Punjab has much in common with other parts of rural India' (Wyon and Gordon, 1971: 98). The study proceeded to state that: 'a statistically valid random sample of villages would have produced more reliable results' but do not tell us why this procedure was not followed. As a matter of fact, the study population and the controls were actually selected purposively for accidental and logistical reasons. In other words, there is a great deal of dissembling here.

That such a deeply flawed study should nonetheless be so influential was due obviously not the validity of the study conclusions, but to other factors. In other words, such a study was needed to justify intervention, to justify a certain policy trajectory, and what better place than Harvard to produce a 'scientific' study that would produce exactly such a justification? We see here an excellent example of the profound confusion caused by the inflections provided to demography by the concerns of the day, the transformation from a discipline meant to understand a problem to doing something about it—something that Hodgson drew our attention to in the last chapter.

Two other birth control field studies with an experimental design comprising a study population were also carried out around the same time. One was the Kyong Study conducted in South Korea and the other was the Singrur Study conducted in West Bengal. The Kyong Study, begun in 1962, covered seven villages with a total population of 8,700. A control was established in seven other villages with a total population of 12,000. After two years, the birth rates in the test area had declined by 13.2 per 1,000. But rates in the control population had declined as well: by 11 per 1,000. The rate of decline was also interesting. In the programmes' first year, the rate in the test population declined by 9.7 per 1,000 and those in the control by 6.8 per 1,000. In the second year, the decline in the test population was only 3.5 per 1,000 while in the control it was 4.2 per 1,000. As in the Khanna Study then, it is not possible to attribute the decline in the test population to intervention alone. Yet, as in the Khanna Study, this is what was done.

Similarly in the Singrur Study in 1957, the decline in the birth rates in the test population was almost twice that in the control population. However, looking at the trend in the birth rates before the programme started, Mamdani has revealed that this difference existed prior to the

intervention (Mamdani, 1972). Indeed the decline in the birth rates before the programme was 3.2 per 1,000; in the four years of the intervention, it was 5.1 per 1,000. There was then no necessary connection between the programme intervention and the birth rates at the end of it.

What all these studies shared other than methodology was a profound misinterpretation of the study results stemming from an *a priori* understanding of the relationship. What they also shared is what Mamdani describes as a profound misunderstanding of the population issue. As one of the leading demographers, Dudley Kirk, acknowledging the limited success of family-planning programmes, explained: 'Given the favourable attitudes found in surveys, family planning may be easier to implement than major advances in education, or the economy, which require large structural and institutional change in the society as a whole' (cited in ibid.: 17). It was these studies that furnished the data on the favourable attitudes to family planning and indeed the programme structure and content.

Mamdani did the methodologically daring. His study, carried out in the same area as the Khanna Study, sought an alternative understanding of the population problem. This he did by locating the 'problem' in a context; by way of understanding the living and working conditions of the population, the role of technology in a given social context, the importance of family labour, and the influence of all these factors in shaping the desired family size. He argued that given the material conditions of the population studied, there existed a necessity for family labour, which in turn determined family size. There was, therefore, rationality in the given socio-economic context for the peasants' desire for a large family. This desire then, was not rooted in either ignorance or irrationality. Indeed, he concludes that by and large, for all sections of the agrarian population, resorting to family planning would be 'to court economic disaster'.

Mamdani's respondents confessed that they had by and large deliberately misled the investigators in the Khanna Study. They had done so for various reasons. Since they did not want to be impolite, they had given the responses that they knew were expected of them, because this was what the investigators wanted to hear. Saying otherwise meant that the investigators often got into trouble with their bosses and jeopardised their careers. It also meant endless and repetitive visits by the investigators to educate and motivate them. It was easier for everyone concerned to reply as they had done. Even after the

completion of the study, the villagers in Manupur remained puzzled by the purpose of the Khanna Study. Some thought the investigators were just ignorant, while others attributed other motives. As one farmer explained to Mamdani: 'These Americans are enemies of the smile on this child's face. All they are interested in is war or family planning' (Mamdani, 1972: 147).

Mamdani's study, however, lays itself open to the charge of being largely anecdotal and hence meriting little weight (Mueller, 1976). Based on the ethnographic method, it obviously did not provide quantitative data. Since no quantitative data was provided on the family size in the different economic groups, we do not know if the desire for family labour expressed by his respondents was actually reflected in the size of families. We also do not know what the socio-economic factors moulding fertility meant for health and infant and child survival. Given the great differentiation in the peasantry that Mamdani testified to, it seems improbable that all sections of the peasantry desired more children. Indeed with the exception of the numerically small, educated Brahmin community shifting into more diversified and urban occupations, there was no group which desired a small family even among the non-peasants in the population. According to Mamdani, even the rich farmers, who had an economic need for curtailing their family size—in order to prevent fragmentation of land—had a social necessity not to do so. In effect, he undermined his own argument. Why, for instance, would the agricultural labourers desire more children given their unemployment and underemployment? Mamdani did attest that in this class children could not be expected to provide old age security. What is perhaps most ironic is that although Mamdani differed fundamentally in understanding the issue from Wyon and Gordon, he too seemed to believe that it is empirically true that the poor have more children. The former believed this to be true because people were ignorant and unaware of modern methods of contraception; they further believed that this is what caused poverty. Mamdani, on the other hand, argued that this was true because people need children; indeed that children are needed precisely because of poverty. Hawthorn, writing about Mamdani's work remarked: 'Despite its unconventional method and its moral and intellectual distance from the University of Chicago and the micro-economic models of fertility developed there and elsewhere in the United States, it did lend some weight to the arguments behind such models' (Hawthorn, 1978: 1).

A large number of studies under the rubric of labour theory came into being but the matter continues to be contentious. Some of them provided evidence substantiating Mamdani's contentions while others questioned it.[2] Some of these differences stem from differences in methodology, above all in the fact that not enough attention has been paid to differentiation within rural populations. Nevertheless the labour theory was subsequently utterly reified in the micro-theories of fertility such as those by Gary Becker, which bring the absurdity of applying cost–benefit analysis—that arithmetic of woe—to the bearing and rearing of children (Becker, 1960). Treating a child as they would any other consumer durable, such as a refrigerator, what this prolific school forgot was that children are not utilities that can be bought or exchanged in the market (Leibenstein, 1977). They also came in for scathing criticism from feminists who argued that such microeconomic theories were normatively misplaced and methodologically foolish (Blake, 1968; Ferber and Nelson, 1993; Woolley, 1993, 1996).

Recalling Arsene Dumont's model of differential fertilities, Rao takes us further in understanding the relationship between economic groups, family size, and the response to family planning that might emerge (Rao, 1976). Since this is not a model that has been studied, and yet is so eminently worthy, I shall dwell on this in some detail. Rao commences with the convincing proposition that irrespective of the expenditure on family planning, there would always be a number of people in society motivated to accept birth control. If, therefore, the number of acceptors of the family-planning programme is not strictly a function of the expenditures on family planning, what might be the other factors that may be said to determine fertility? He argues that there are two crucial factors: infant mortality and the desired family size.

Examining the relationship between infant mortality and fertility, it seems fairly obvious—this has, in fact, been empirically demonstrated and forms the heart of the demographic transition theory—that as survival rates improve, birth rates remain flat and growth rates rise up to a point. After that, birth rates begin to fall and fall more than proportionately. Thus growth rates begin to decline. The initial unresponsiveness of birth rates to improvements in mortality is due to the fact that at very low survival rates, the minimum number of children required to ensure the survival of some children, with confidence, may be so large that it might well exceed the fecund capacity of the

mother, or the economic capacity of the family to support so many children. The number of children a couple might end up with, on average, may thus be larger than the desired number of children. Conversely, given the uncertainties of child survival, it is also true that families who desire more children, might, on average have less than this number due to infant and child mortality.

Rao next examines the desired family size of different economic groups, considering both the cost of children and the motives parents, in general, have for children. He assumes, of course, that all parents love and desire children for their own sake—which might astonish the economists of the microeconomics models. He distinguishes four groups on the basis of income and the ownership of property. Class I or workers, consists of landless labourers in rural areas and industrial manual workers in urban areas. This class is characterised by low levels of income, lack of access to productive resources and dependence on others for employment. Class II or peasants or petit bourgeosie consists of small peasants who cultivate land mostly with family labour, and petty traders and artisans who live by household industry. This class is characterised by self-employment and a higher income level than Class I. Class III comprises capitalist farmers, industrialists, and big traders. The members of this class are characterised by the fact they live by ownership of property, employ others, and, of course, command a large income. Class IV comprises professional classes who enjoy fairly high incomes, higher than Classes I and II, have occupations that require skills through education. This class includes civil servants, academics, doctors, and so on.

Rao distinguishes the cost of children as the direct cost of feeding, clothing, and so on, and the indirect cost of women having to forego employment due to the demands of childcare. He postulates that women in Class I take up employment because it boosts family income considerably. In Class II, employment is usually confined to family enterprises. In Class III he assumes that women typically do not work. In Class IV women do, of course, take up employment, although not as often as in Class I. The indirect cost of children, therefore, falls as we move from Class I to Class III and then rises in Class IV. The direct costs have a proportion of income also has a similar pattern. Thus the total relative costs are lowest in Class III and rise slightly between Class III and Class IV.

He distinguishes two economic motives for children: one, that children are a source of income and two, the insurance motive—children

provide security in old age. The motive for children as a source of income would be strong in Class I as income levels are low. This, however, would be offset by other factors such as the low levels of employment, its seasonality and the nucleation of families in this class. The net addition to family incomes in this class would thus typically be low. In Class II, the income stream associated with a child would be greater than in Class I, both because the chances of employment are higher, and also because children are likely to stay on much longer in parental family due to the dependence on family property. The motive for children as a source of income would be typically low in Class III because incomes are high and are not earned by work. Children in this class would, therefore, be required to manage property, but weighing against this is the fear of the sub-division of property. Again, in Class IV, the motive for children as a source of income would be weak, although not as weak as in Class III.

In Rao's model, the insurance motive for children is likely to be high among workers (Class I), but it is precisely in this class that parents cannot depend upon any one child alone, since the income earned is small, forcing safety in numbers. In peasant and petty bourgeois families (Class II), the insurance motive is likely to be stronger. In Class III, the insurance motive is likely to be weak, and in Class IV, it is likely to be strong again, since parents do not live on property.

On balance, therefore, the net motivation for children may be strongest in Class II and weakest in Class III; motivation is stronger in Class I than in Classes III or IV. It is not, argues Rao, cultural factors or traditions that determine levels of fertility, but objective socio-economic factors such as the nature of livelihood and the chances of child survival.

It is a great pity that Rao's model has not been empirically tested. The empirical data he himself mobilises in support of his model is patchy. Indeed Rao admits as much himself when he notes that this model is based on certain assumptions, the empirical validity of which remain to be tested (Rao, 1974). Rao's model is also weakened by his rather idiosyncratic classification of the peasantry; property does not a capitalist make! Nevertheless it provides a model, to be refined no doubt, for the classification of populations so that the influence of a number of factors—mortality, fertility, access to healthcare and

contraceptive services and so on—in these discrete groups in the population can be studied.

A large study carried out in the 1950s investigated the relationship between mortality, fertility, and socio-economic variables (United Nations, 1961). The Mysore Population Study sought reliable answers to the following questions: How high was the birth rate? What was the death rate in different sections of the population? How had social and economic changes wrought changes in these rates? Although it is known 'that that there are differences in fertility related to rural or urban residence, caste, occupation, education, levels of living etc. ... these are fragmentary, somewhat inconclusive, and in some instances contradictory' (ibid.: 6). With this in mind, the Mysore Population Study sought an adequate classification in order to understand these factors.

With this in view the study was distributed over a large city, Bangalore, several smaller towns and villages in several agro-climatic regions forming six rural zones. But the classification adopted was highly inadequate. In Bangalore city, five zones were drawn up based on religious composition. In rural areas, two fairly large sections of the population, namely, those living in huts and those living in better types of houses but with no working member were excluded from the study for inexplicable reasons. The rest of the rural population was classified on the basis of tenure and land ownership into the following groups: labourer or temporary tenant; owner cultivator with less than 3 acres of land or permanent tenant with less than 5 acres, and owner cultivator with more than 3 acres of land and permanent tenant with more than 5 acres.

The rationale for this curious and incomprehensible classification—based not just on the inadequate criterion of landholding but also the confounding one of tenure—was not specified. Mystifying, this stratification is also logically incomprehensible. It would appear that landlords in rural areas have been left out. Or, if included along with owner cultivators with more than 3 acres, would obviously distort the composition of this group, which presumably would consist of rich and middle peasants, and possibly some poor peasants hiring in land. The aggregation of owner cultivator with tenants would further confound the groupings, since a tenant, a juridical category, can consist, in class terms, of any section of the peasantry, from the rich peasant to the poor peasant.

The study found that:

(*a*) in rural areas the families of agricultural laborers and temporary tenants had the highest infant mortality rate;
(*b*) there was a relatively low birth rate in the same groups; and
(*c*) higher birth rates were found in higher socio-economic groups.

These were truly remarkable findings, going against the grain of much received wisdom and 'common sense'. But this finding did not receive the attention it might have in the welter of data generated by the study. There were, in fact, other remarkable findings: that although levels of contraception were low, the fertility levels were lower than in other countries at comparable levels of demographic transition. Thus the average number of children born was about 6.7 in Bangalore city and 6.5 in rural areas, whereas a similar cohort of women in England, as per the 1911 Census in England, had 8.4 children. In rural Quebec according to the 1941 Census in Canada, the average number of children was 9.9. This finding, in fact, begged for further research or analytic explanation. Further, the study also found that there was no monotonic relationship between education and fertility—which is now increasingly being recognised. In Bangalore city there was no appreciable difference in the fertility below the level of high school education and in rural areas, the illiterate were less fertile than women who were literate or had attended the upper primary and middle schools. It was only women who had above high school and university education who had the lowest fertility. In other words, there was a curvilinear relationship, with fertility increasing with education and then declining with further education, much as land-holding is known to do in other studies. There was a clear positive association between fertility and economic status in the rural areas. In the urban areas the lower non-manual groups and skilled manuals show slightly larger families than other occupational groups. Indeed the Mysore Population Study's finding that fertility rate declines as survival of children increases is used by Rao to flesh out his study (Rao, 1974). Thus the number of children born per woman in the rural hills with a survival rate of 56 was 7.2; the number of children surviving per woman was 4. In rural plains, with a survival rate of 62, the number of children born per woman was 6.3; the number of children surviving per woman was 3.9. In Bangalore city, with a survival rate of 66, the number of children born per woman was 5.2 and

the number of surviving children per woman was 3.4. As is obvious this data is not presented in relation to social groups considered earlier for birth rates and death rates.

The Mysore Population Study, in other words, threw up a range of intriguing—indeed challenging—data that called for further exploration, using possibly more refined methods of classification. Yet what we had, following upon this, was a methodological backsliding to the Khanna Study. This again illustrates a point made earlier that it is not possible to see what the mind does not conceptualise, or indeed want to know. This is not to argue that there was a scientific conspiracy, inspired by funding from the population control establishment, which moulded the research. Such an argument would be too simplistic, and does not take into account how the climate of the times influences not just research priorities but also ways of conceptualising an issue.

That the Mysore Population Study was not just a flash in the pan is revealed by yet another large-scale study carried out in five districts of Uttar Pradesh (Misra et al., 1982). Misra et al.'s study was to understand the functioning of the family-planning programme and the reasons for the poor response it received. This study utilises what is described as an open systems framework, to emphasise the interrelatedness of factors—economic, social, demographic, and organisational—which govern family planning acceptance. The study covered a massive sample comprising 45 primary health centres (15 each in poor, average, and well performing PHCs selected at random) and 3,000 couples selected at random. The focus of the study was, however, to understand the implementation of the programme and thus largely pertained to what were called organisational factors. Yet, in order to understand the environment in which the programme was located, social and demographic factors were also studied.

The stratification of the study population was based on the inadequate criterion of landholding. Without going into the details of the study, the significant findings that emerged were that the mean household size and land ownership are positively related. The landless poor thus have the smallest household size. Infant and child mortality were extremely pervasive with the majority of families experiencing the death of at least one child; of those who had more than two live births, the majority had seen at least one child die. Possibly because of its pervasiveness, infant and child mortality data is not presented in relation to income and landholding. Given the nature of the agrarian

economy, it is not surprising that a substantial proportion of the population felt that children played an important role in the household economy—although this data is not provided by income or landholding categories. It is thus not surprising that from the perspective of the study population, population growth or family size are not problems either for themselves or their villages. The conclusion that the study comes to is that socio-economic conditions act as a barrier to fertility reduction—neo-Malthusian thinking turned on its head!

While the critical importance of socio-economic factors is glaring, the authors themselves do not give this the attention it deserves. Thus much of the data—education, age at marriage, desired family size, and so on—is not presented in relation to landholding or income strata. The study does note that income, caste, education, and landholding are closely related.

Djurfeldt and Linberg in their anthropological study of a village in Tamil Nadu note the very marked differences in fertility between different agrarian classes (Djurfeldt and Lindberg, 1975). The mean number of births per woman among the big farmers was 5.15, 4.05 among middle farmers, and 3.42 among small farmers and landless labourers. Now, although this is not standardised for age structures, it nevertheless indicates something significant. These authors too highlight the role of children both in the household economy and as insurance in old age. But this data is not presented in relation to the socio-economic categories they employ. The classification of the peasantry is again based on landholding, which I shall argue next is misleading for a number of reasons.

Yet another more recent anthropological study in a village in Rajasthan provides data on births and deaths by socio-economic groups (Patel, 1994). This study finds fertility increasing as we move up the class hierarchy up to a point, beyond which it again comes down, the familiar curvilinear relationship that we have seen earlier. Fertility is lowest among mothers in the lowest income groups, primarily the landless or those with meager patches of land, followed by those in the richest, to the apparent surprise of the author. What is extremely interesting is Patel's finding that in the village 'cosmology of income, expenditure, consumption and work, a simple calculation of cost and benefits of children does not find any expression. People do not think in terms of "a baby or a car". A child is not seen as a choice made against some consumer durable. An attempt to evaluate fertility behaviour in terms of such a choice is both absurd and

irrelevant' (Patel, 1994: 95). Indeed the values attributed to children and the social and symbolic returns that accrue to parents are supportive of high fertility.

Patel also documents the pervasive occurrence of infant and child deaths, with every other woman in the study village having lost a child or more. Thus parents are rarely confident about the survival of children born to them. This fear of child mortality haunts the population, persisting in what the author calls practical consciousness in the collective experience of the villagers. The cases where a woman has no surviving child despite having given birth to one or two children is 'frightening to all others' with people hopeful of child survival only after having had four or five children. Poignantly, a child's death is referred to as a burning of the womb, the 'death of a child metaphorically equated with the burning of the household to ashes' (ibid.: 141). Although mortality has declined in the study area, this has not been internalised with the precariousness of child survival etched still in people's perceptions. Unfortunately, Patel does not provide us the mortality experience by socio-economic groups.

One of the large-scale sources of data is of course the National Sample Survey (NSS), which too offers data on births and deaths by socio-economic groups. The data are mysterious, if not seriously misleading; at the very worst they are utterly confounding. As per the 15th round, the infant mortality rate rises progressively with increasing per capita monthly household expenditure (GOI, 1960). That this is not simply an aberration is supported by the fact that this unbelievable finding is supported by data collected during the course of the 16th and 17th rounds that confirm this finding (GOI, 1961, 1962). The annual death rate per monthly per capita household expenditure shows that in the households with a monthly per capita expenditure of more than Rs 21 was slightly higher than in households with a monthly per capita expenditure below this.

The NSS data also indicate that the birth rate declined with an increase in monthly per capita household expenditure. In other words, it indicated what was seen to be common sense: that the 'poor' bred more than the rich. While this could ruffle no feathers, how does one explain the fact that mortality, and especially infant mortality, rises with rising per capita expenditure? Krishnaji has convincingly demonstrated that the 'error' in the data does not arise merely from sample size or recall errors but from a statistical distortion due to the very use of monthly per capita expenditures as an independent variable (Krishnaji, 1980).

To illustrate, consider a family of two with a monthly per capita expenditure of say Rs 50. A birth in this household would diminish the per capita expenditure by a significant third, pushing the family down in the hierarchy. If this child were to die, the per capita expenditure would increase by a third, pushing the family into a higher per capita expenditure category thus bringing about a spurious association between per capita expenditures, births and deaths. In other words, this is fundamentally flawed methodologically.

The NSS data also gives rise to inconsistencies in the relationship between per capita household expenditures, death rates, and household size. Thus the data reveal that the size of the household increased with increasing landholding. This does not sit comfortably with the fact that these households have a lower birth rate and a higher death rate and infant mortality rate, associated with higher per capita monthly expenditures. It is thus not surprising that NSS data do not inspire much confidence among scholars (Cassen, 1978). Indeed Krishnaji concludes that they only conjure a statistical mirage (Krishnaji, 1980).

Gupta and Malakar have also drawn attention to the severe problems with the use of per capita expenditure to study demographic differentials (Gupta and Malakar, 1963). Finding the association between increasing per capita expenditures and infant mortality rates unacceptable, they utilised the NSS data, reclassifying the households using a level of living index based on the consumption of so-called luxury items in the diet. They obtained with this method, using the same set of NSS data, quite a radically different picture. With increasing levels of living they found that the birth rate increased up to a point after which it again declined. In other words, they found a curvilinear relationship between increasing levels of living and fertility. As Krishnaji has noted: 'Family size and death rate "paradoxes" arise wholly out of inappropriate use of indices for analyzing demographic differentials. On the logical plane, these paradoxes disappear once we bring in an appropriate variable such as property holdings' (Krishnaji, 1984: 257).

The National Family Health Survey offers some extremely interesting data on demographic differentials and some of their determinants (International Institute of Population Sciences [IIPS], 2000) Unfortunately while there is a stunning amount of data, it is not always presented with reference to concrete socio-economic categories. We thus have, in addition to data by state, region, and rural–urban differences, data on births and deaths (but not of family size) in relation to

education, religion, caste, and so on. The data unambiguously reveals a fertility decline in all groups. There are nevertheless still significant differences in the total fertility rate (TFR): it is 1.3 children higher for women living in households with a low standard of living, and 0.8 child higher for those living in households with a medium standard of living than in those living in households with a high standard of living. In other words, the poor have higher fertility. Children of women belonging to Scheduled Castes (SCs) and Scheduled Tribes (STs) have higher rates of infant and child mortality. Households with a low standard of living have infant and child mortality rates two and three times higher than households with a high standard of living. There are also significant differences between these groups in terms of nutrition, morbidity, health status, health services outreach, access to immunisation, and so on. Interestingly, even unmet need for family planning is substantially higher among the poorer groups. But these are all-India figures including both rural and urban areas, and not all the data is consistently presented in terms of these groups.

Another recent and large study finds similar levels of fertility in all landholding groups, but higher fertility among the landless. Nevertheless it notes that there is not much variation in fertility with rising household income, but that fertility is related to overall development, falling as village development improves. This study also finds that the rich have a CDR of 7 per 1,000 compared with 13 per 1,000 among the poor. However, infant mortality rates and child mortality rates are not presented in relation to either landholding or income (Shariff, 1999). It appears then, that all large-scale studies seem to forswear categorisation of the population by meaningful social groups or class categories.

I have frequently alluded to the fact that stratification of households on the basis of landholding is both inadequate and imprecise. The criterion of landholding, while possibly indicating the economic status of a household, is not adequate as an index of the economic class of a household. Patnaik has forcefully demonstrated the manifest inadequacy of treating farm size as a sufficient index of class status (Patnaik, 1987). She argues that farm acreage cannot provide any analytical explanation, and provides very poor statistical explanation of observed variation in farm economics. Any acreage grouping, for example, such as the 5 acres and below used by the Mysore Population Study, contains every type of household in terms of class categories, ranging from the very poor agricultural labourer with land to

the small scale, self-employed peasant, and the primarily hired-labour based rich peasant.

If landholding run on different organisational bases, namely, with hired labour and with family labour—differed only in the extent of acreage operated, the criterion may possibly have been satisfactory. But in reality, however, they differ significantly with respect to other factors also. At the simplest, an acre of high fertility or irrigated land differs from an acre of low fertility or rainfall-dependent land. Even if standardised acreages are utilised, the same area can be cultivated with a low productivity level of technique or with a high productivity level of technique. The intensity of cultivation, depending upon the extent of capital investment, can also vary a great deal. The greater the variation in techniques and methods of cultivation, the more inaccurate becomes farm acreage as an index of both the scale of production and of class status. Thus, it is not legitimate to include a family-based, cereal pulse cultivating holding of 5 acres with a hired-labour based intensive cultivator of flowers for export in the same class category simply because the latter also owns 5 acres. The inadequacy of farm acreage as an index of class position is even more striking in a situation of technical change. In a given acreage group, the better-off cultivators, already using some hired labour, would be able to invest in new inputs, expanding the scale of production and generating larger surpluses. In the same acreage group, the poor peasants in deficit and the small peasant just breaking even, would be unable to take advantage of the new technology, and thus their relative position would worsen. By lumping together both types of holdings, acreage groupings would obscure class differences (Patnaik, 1987).

Data on the ownership of both land and other means of production indicate a high degree of concentration of both land and non-land resources in India. The implication of this is, of course, a high degree of differentiation within the peasantry. Agrarian classes thus need to be carefully distinguished on the basis of not just the ownership of resources but also the utilisation of labour. In other words, at the heart of the concept of class is whether a household is primarily dependent on exploiting the labour of others, whether it is primarily self-employed, or whether it is primarily exploited (ibid.).

It is important to bear this in mind because part of the confusion in demographic studies lies in not appreciating these differentials in the peasantry. This is quite surprising since it is widely accepted that

one important determinant—indeed if not the most important—of family size is the class location of families. This not only determines labour utilisation, but is also a determinant of a range of other factors impinging on health such as mortality, nutritional status, access to health services, and so on. As is evident, we do not have any large-scale study using this criterion.

In an interesting departure from using incomes and landholdings for the stratification of study populations, Ansari uses the concept of the family's production function in order to classify them in villages of Tanda tehsil in Faizabad district of Uttar Pradesh (Ansari, 1994). Questioning Malthusian orthodoxy, he hypothesises that family size would logically follow the needs of households for labour, this decided, among other factors, on whether they own the means of production of material goods or not and how they utilise labour in order to produce goods. Studying two populations of peasants and weavers, he classifies households as those that are both units of consumption and production, in other words households with access to either land or looms where family labour is utilised in production and households which are units of consumption and not of production and so on. Among his findings is the familiar fact that among agrarian populations, nuclear families predominate in landless and marginal peasant households, with the prevalence of joint families increasing as we move up the class ladder. In other words, what may be called the 'joint-ness' of households was a function of landholding. Household size and family size increased as one moved up from landless labourer to marginal peasant, middle and rich peasants. Family size was largest in units where production held the family together: 4.71, while it was lower in household units which were primarily units of consumption: 4.54.

What is also extremely revealing is the large socio-economic and production differences among weavers, a group almost always treated homogenously as artisans. Thus we have the *karigars*, skilled weavers who do not own looms but hire out their labour. Above them were the *bani bunkers* who owned looms but could not afford to arrange a consistent supply of yarn and other raw materials and were thus dependent on traders. The *bani bunkers* obtained the raw materials from the traders to whom they sold the finished product, utilising the labour of the entire family in production. Above these were the independent weavers who owned looms and bought all their own materials, and were free to sell in the market. The independent weavers also used family labour but also frequently hired *karigars*. At the peak

of the hierarchy were the master weavers who owned a number of looms and primarily employed skilled weavers, with household labour mainly performing a supervisory and managerial role.

Here too we have the finding that ownership of the loom appeared to demand a large family size: the average family size was 4 among the *karigars*, 4.5 among the *bani bunkers*, 4.88 among independent weavers, and 5.10 among master weavers. What is intriguing here is the monotonic relationship between ownership of looms and access to raw materials and family size. That is to say, we do not see the curvilinear relationship that is familiar from agrarian populations. This is not, however, a factor that has been investigated in this study and begs enquiry. An equally interesting finding was that Dalit and backward caste households were not represented among independent and master weavers. The degree of joint-ness of families also increased as we moved up the hierarchy. In other words, ownership of looms and raw materials was associated both with a larger family and but with increasing household size.

Among the other factors that contributed to these findings was the fact that infant and child deaths were largely concentrated in households that did not have access to either land or looms, and decreased up the class hierarchy. The mortality rates among the landless labourers and *karigars* were twice that among rich peasants and master weavers.

My own study was carried out in three villages of a primarily agrarian area utilising advanced techniques in Mandya district of Karnataka (Rao, 1995). For purposes of stratification, Patnaik's labour exploitation ratio was utilised (Patnaik, 1987). This is an index of the labour hired in or hired out in relation to family labour in self-employment and is an empirical index for classification of households. On the basis of the labour exploitation ratio, the following peasant classes were identified:

(*a*) Classes primarily exploiting labour:
  (*i*) Landlord
  (*ii*) Rich peasant
(*b*) Classes primarily self-exploited:
  (*i*) Middle peasant
  (*ii*) Small peasant

(*c*) Classes primarily exploited:
  (*i*) Poor peasant
  (*ii*) Landless labour
(*d*) Non-peasants.

The data revealed that of the 584 households, the largest proportion belonged to the rich peasant class followed by the landless labourers and poor peasants. In this primarily agrarian population, in an area of advanced agricultural techniques and production, there had indeed occurred a polarisation of classes as attested to also by Epstein work in the same area (Epstein, 1973). The idealised, primarily labour-based, supposedly self-sufficient peasant household of Chayanovian middle peasants comprised merely 10 per cent of the population.

The data on the distribution of families by size in relation to class is presented in Table 3.1. What is immediately striking, is that in this primarily agrarian population around 50 per cent of families comprised up to only four or less members. This challenges the common sense assertions regarding the family size of agrarian populations, of teeming families. The second significant finding was that it was in

Table 3.1 Distribution of Families by Size in Relation to Class

Class	*Family Size (Number of Members)*			*Total Households*
	1–4	*5–9*	*10–14*	
Primarily exploiting labour				
Landlord	16 (2.4)	31 (4.6)	0	47 (7)
Rich peasant	117 (17.5)	141 (21)	3 (0.4)	261 (39)
Primarily self-exploited				
Middle peasant	40 (6)	37 (5.5)	1 (0.1)	78 (11.6)
Small peasant	18 (2.7)	11 (1.6)	0	29 (4.3)
Primarily exploited				
Poor peasant	63 (9.4)	48 (7.2)	2 (0.3)	113 (16.9)
Landless labour	66 (9.9)	47 (7)	3 (0.4)	116 (17.3)
Non-peasant	15 (2.2)	10 (1.5)	1 (0.1)	26 (3.9)
Total	335 (50)	325 (48.5)	10 (1.5)	670 (100)

Note: Per cent in parentheses: proportion of total families.

Table 3.2 Proportionate Distribution of Families by Size and Mean Family Size in Relation to Class

Class	*Family Size (Number of Members)*			
	1–4	*5–9*	*10–14*	*Mean Family Size*
Landlord	37.04	65.95	--	5.02
Rich peasant	44.82	54.02	1.14	4.76
Middle peasant	51.28	47.43	1.28	4.55
Small peasant	62.06	37.93	--	4.66
Poor peasant	55.75	42.47	1.76	4.42
Landless labour	56.89	40.51	2.58	4.43
Non-peasant	57.69	38.46	3.84	4.38

the primarily exploiting classes, namely, the class of the landlord and the rich peasant, that a larger family size was more prevalent. This is along the lines of Ansari's findings.

In order to highlight these differentials, Table 3.2 presents data on the proportionate distribution of families by size in each class along with the mean family size. The data here reveal that in general, with declining class status, the proportion of families with a smaller size increases. The landless labour and the poor peasants had the largest proportion of families comprising up to four members alone. The difference in the proportions between this class and the class primarily exploiting labour was statistically significant. The mean family size was lowest in the agrarian population among the landless labourers.

The size of a family is dependent on the following factors: selective migration, fertility, and mortality. A striking finding of the 1991 Census was that there was a dampening of rural–urban migration; indeed dependence on agricultural employment may well have increased over the previous decade (Kulkarni, 1994). This attests not so much to the absence of push factors in the agrarian economy as perhaps the weakening of pull factors in the urban. Nevertheless the import of this finding is that we may discount selective out-migration as a factor to explain these perceived differentials in family size. A number of mechanisms have been postulated through which the comparative fertility of the poor would be lower. These include a higher age at menarche for girls, a larger number of anovulatory menstrual cycles among women—perhaps induced by undernutrition, longer post-partum amenorrhoea due to prolonged breast feeding, pregnancy wastage, still births, and so on (Gopalan and Naidu, 1972).

Table 3.3 Distribution of the Children Ever Born Ratio in Relation to Class Groups

Class	*Age*				
	11–15 years	*16–25 years*	*26–35 years*	*36–45 years*	*Total*
Primarily exploiting labour	61.53	201.85	395.78	556.52	333.55
Primarily self-exploited	66.66	184.00	420.00	625.00	322.23
Primarily exploited	93.77	206.66	375.00	503.92	315.13
Non-peasant	–	144.44	290.00	533.00	296.00
Total	72.54	192.99	386.02	548.66	324.86

An index of fertility that can be utilised, albeit as a proxy for fertility rates, is the children ever born ratio. This is given by the formula:

$$\text{Children ever born ratio} = \frac{\text{The number of children ever born to women in an age cohort}}{\text{Number of married women in the age cohort}} \times 100$$

Table 3.3 presents the data on the distribution of this ratio by class groups in the study population.

Although the differences among these class groups are not statistically significant, given the nature of the study and thus the sample size, it is nevertheless quite arresting that women among the classes primarily exploited have in general a lower level of fertility than the other peasant classes. Indeed, in the age group 36–45 years, towards the end of the reproductive life span, the differences in the children ever born ratio assumes statistical significance. Among the non-peasants, of course, there are no women married in the 11–15 years age group and fertility is decidedly lower than among the peasant groups in the age cohorts of 16–25 years and 26–35 years.

Even in the agriculturally dynamic and relatively prosperous area, infant mortality—although declining—was still unconscionably high: almost one in three women had experienced an infant death, while among the landless labour and poor peasants every other woman had suffered the trauma of an infant death. To obtain an idea

of the distribution of infant deaths in the study population we use the index of infant death ratio.

$$\text{Infant death ratio} = \frac{\text{Total number of infant deaths among married women in an age cohort}}{\text{Total Number of married women in the age cohort}} \times 100$$

Table 3.4 Distribution of the Ratio of Infant Deaths by Cohorts of Married Women in Relation to Class Groups

Class	*Age*			
	16–25 years	*26–35 years*	*36–45 years*	*Total*
Primarily exploiting labour	14.81	38.94	82.60	36.91
Primarily self-exploited	14.00	55.00	100.00	40.77
Primarily exploited	24.44	59.01	90.19	47.70
Non-peasants	–	30.00	66.66	28.00
Total	17.50	46.77	87.33	40.83

Given the numbers involved, the difference in the infant mortality load among the various class groups obviously is not statistically significant. Yet it is clear that the load of infant mortality increases with decreasing class status; the landless labourers and the poor peasants bear a disproportionate burden of infant deaths (see Table 3.4).

An index of the mortality of infants and children, again as a proxy for infant and child mortality rates—given the size of the sample—is the child survival ratio. This is given by the following formula:

$$\text{Child survival ratio} = \frac{\text{Total number of infants and children ever born surviving among married women in an age cohort}}{\text{Total Number of married women in the age cohort}} \times 100$$

Table 3.5 provides the data on the distribution of this index in the study population.

What this reveals is that among the peasantry as a whole, the child survival ratio decreases with decreasing class position. The differences in the ratio between the primarily exploiting and the primarily exploited in the older ages cohorts of women is statistically significant. In other

Table 3.5 Distribution of the Child Survival Rario by Cohorts of Married Women in Relation to Class

Class	*Age*				
	11–15 years	*16–25 years*	*26–35 years*	*36–45 years*	*Total*
Primarily exploiting labour	61.53	184.25	344.21	443.47	284.56
Primarily self-exploited	66.66	170.00	360.00	504.16	275.72
Primarily exploited	93.75	178.88	291.80	374.50	250.30
Non-peasant	–	144.44	220.00	450.00	248.00
Total	72.54	178.21	322.04	430.00	270.03

words, that poor peasants and landless labourers have the least chances of child survival.

Although the data is from a small study, it nevertheless uambiguously reveals that the poor in rural India (largely synonymous with the landless agricultural labourers and poor peasants) have the largest proportion of nuclear families, the smallest household size, and the smallest family size (Rao, 1997). What is also interesting is the almost unique response of parents in every class to the issue of their perception of children as economic assets or as providers of security in old age. The largest proportion of parents who perceive their children as economic assets is in the middle peasant class, followed by the rich peasant class. Poor peasants and landless labourers on the contrary, by and large, do not perceive their children as economic assets. Here, then is data, to substantiate Rao's model, discussed earlier. Similarly each class has a distinct identity when it comes to shaping parental perception of security in old age: as we move down the class hierarchy, the proportion of parents perceiving children as a source of security in old age declines.

Yet another study in a village in Coimbatore district of Tamil Nadu came to similar conclusions (Nakkeeran, 1998). Classes primarily hiring out labour had a higher proportion of infant and child deaths, with classes primarily hiring in labour experiencing lower infant and child deaths from a generation earlier. This study also found a curvilinear relationship between family size and landholding with family size increasing as we move up the class hierarchy, up to a point and then declining. This study concluded that: 'families hiring in labour appear to be assured of not only child survival but

of surpluses to allow transition into a more secure urban economy where the role of children in the household economy is altered' (Nakkeeran, 1998: 203). Contributing significantly was the unique role of women in the household economy—and thus her status—within each class. In other words, women in each class are differentially oppressed! The overall decline of employment has affected women differentially, with the landless and the marginally landed seeing severe erosion in their contribution to the household income.

Both the studies discussed also indicate that health services are particularly inaccessible to the primarily exploited classes. What is offered to women from these classes in terms of contraceptive choices is sterilisation. As Nakkeeran concludes:

> Women (of these classes) are thus offered two hard choices. One is to undergo sterilization, in which case women have to be ... prepared to forego employment and income. The other option is not to undergo sterilization, but to stay fit and work harder to earn, but with the risk of bearing another child. With diminishing employment, and the available employment becoming increasingly taxing, more and more women are forced to opt for the former option. (ibid.: 216)

The data we have reviewed so far—some from large studies, many from smaller ones—point to several important factors. First, they underline the critical importance of differentials in fertility, and, therefore, of their determinants. Above all they draw attention to the overwhelming fact that fertility, mortality and so forth are not simply biological characteristics, or spatial and geographical characteristics, but socially inscribed processes that need to be understood as such. Second, they also draw attention to the fact that there is a profound need to adequately conceptualise and concretise how best to capture these differences, in order to understand some element of causality. In other words classes need to be defined in relation to real and empirical factors. Too large a classificatory net would mean that we lose out important differences, lumping together disparate groups. Third, that the blanket term 'poor' is inadequate as an analytical category. Yet the most frequent trope we hear is that the poor—through folly, ignorance, or irrationality—breed incontinently and that this is what is responsible for their own poverty and the poverty of the nation as well. The data from the range of studies here, both historical and contemporary, have decisively put paid to this neo-Malthusian

red herring. What they also show is that we have to think in terms of larger explanatory scheme, giving up a ruthlessly monocular vision. Perhaps we need to explore the idea that births and deaths—and changes in their rates—are linked intimately and determined by structures of production and distribution in society. In other words, that these are not merely natural, but distributed as unevenly as resources. Indeed that there are possibly structural constraints to demographic transition in different groups in societies such as India and that this is a social rather than a demographic issue.

NOTES

1. My students are often appalled by Mamdani's study—till they read it. 'How could he critique a study by scientists from Harvard?', they ask. Once they read it, they feel betrayed by scientists from Harvard. What is interesting is that they have never felt that their courses in research methodology should have taught them to look closely at the methodology of studies, in spite of the study authors being from Harvard!
2. I do not propose to go into the vast literature here, but see the work of Kelley (1980), Mead (1973). For the opposite view, that children are not a net asset, see Dasgupta (1978), and Vlasoff (1979).

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4

REIFYING REPRODUCTION

We saw earlier that towards the end of the 1980s, the family-planning programme appeared to have run out of steam yet again. In the past, whenever it occurred, and it occurred with monotonous regularity, that the programme had reached a crossroad, the path forward was frequently decided upon through a technical fix. But now something new was in the offing—a 'paradigm shift'.

The 1980s and 1990s reverberated with debates about reproductive rights, and indeed wrongs. These debates involved women's rights activists, public health workers, policy makers, donors, and academics and continue till this day. One stream of argument sees all reference to reproductive rights—which it resolutely fights—as undermining the family and the community, and is associated with the position of the Vatican, some Islamic countries, and, more importantly, the Protestant fundamentalists who are increasingly setting the agenda in the USA. Another stream, at the opposite end of the ideological spectrum, argues that reproductive rights may perhaps represent population control by other means. Between the two are a range of institutions at the international level that have brought the agenda of reproductive rights to the centre stage, not least among them the World Bank and the Population Council. Placing reproductive rights squarely on the world agenda was the International Conference on Population and Development (ICPD) held at Cairo in 1994. This chapter briefly surveys the factors that shaped the emerging discourse of reproductive rights, tracing the contradictions and ambiguities that surround this discourse and finally questions the epidemiological logic of the approach in countries like India where public health priorities continue to be the quintessential diseases of poverty and hunger.

The concept of reproductive rights has, of course, a long, and one might argue, tragic heritage, with blighted embittered lives, unwanted births, and indeed with a horrific death toll on women,

imposed by society's blind, and blindingly Victorian, 'morality'. We saw in an earlier chapter that various streams of thought, jostling uneasily with one another, congealed into the birth control movement in the nineteenth century gathering strength in the early twentieth century. The most prominent among them, the radical feminists and the socialists believed, and believed strongly, that women had the right to control their own destinies, their own bodies. Access to birth control, then banned, was one element in their larger struggle for democratic rights. The ideas of socialists on birth control were also coloured by the feeling that the burden of repeated pregnancies was harmful to the health of working women; and by the belief that while it was in the interests of the capitalists to have a large working-class population as it provided them with an unlimited supply of cheap labour, it was not in the best interests of the working class. It was thus in the ranks of the International Workers of the World that the first demands for free access to contraception arose (Gordon, 1976). We saw too that ultimately the movement was taken over by the neo-Malthusians whose concerns were quite radically different.

There were two prominent demands underlying the movement: legalisation of access to contraceptives and to abortion. Unwanted births and maternal deaths in childbirth and in abortion caused, to quote William Farr's memorable phrase, 'a deep dark and continuous stream of mortality' (Oakley, 1984: 32).

The late nineteenth century saw the availability of what could be called modern contraceptives due to the invention of the vulcanisation process. But what is also not frequently remembered is that legislation making abortions illegal was also a product of the nineteenth century (Doyal, 1995). This is attributed partly to efforts aimed at the professionalisation of medicine and to efforts towards reducing maternal mortality—although maternal mortality began to decline only in the twentieth century mainly due to improvements in standards of living (Bandarage, 1999: 24). It was also partly due to Victorian prudery and the idea that a good bourgeoise woman was an asexual being. In other words, it was believed that both sexuality and the dolorous outcome of illicit sexuality, unwanted pregnancies, had to be criminalised.

It was within the wings of the Labour Party in England that the demands for the legalisation of contraception and abortion were enunciated with the formation of the Worker's Birth Control Group at the Annual Conference of Labour Women in 1924. Indeed they

met with fierce resistance from the men in the Labour Party.[1] In 1934, the Women's Cooperative Guild passed a resolution demanding the decriminalisation of abortion and in 1936 the Abortion Law Reform Association was for formed (Oakley, 1986). Stella Brown, a socialist and feminist, argued in *The Communist* in 1922:

> Birth control for women is no less than workshop control and the determination of the conditions of labour for men .... Birth control is women's crucial effort at self-determination and at control of her own person and her own environment. (cited in Agnihotri Gupta, 2000: 1570)

But, as we noted in Chapter 2, all such 'liberatory' discourse suffered in the climate of the post First War reaction. Indeed the Soviet Union, which had initially passed far-reaching abortion laws making abortion more or less available on request, quickly rescinded these laws during this period. Along with England and France, the Soviet Union, reeling under the monumental loss of lives in the carnage of the Great War, was hesitant about undertaking measures that were anti-natalist. Indeed so pro-natalist, and gynaephobic, were the times that the first government report in the UK taking note of the high maternal mortality observed that maternal lives needed to be saved as they produced children for the nation (Oakley, 1986). As the world plunged into the Great Depression, the discourse that entered center stage was eugenics.

In the post Second War period, again as we saw in Chapter 2, for a variety of reasons, chief among them Cold War concerns of a population bomb, it was population control that dominated thinking among influential international institutions and indeed the élites of the developing world. The availability of a range of contraceptives seemed axiomatically to guarantee that there was indeed a magic bullet for the population problem. But over the 1970s, a range of groups came to critically examine both the strategies for population control and the assumptions on which they were based. It was abundantly evident that the various strategies of population control simply did not seem to be working. At the same time, the demographic catastrophe that had been forecast simply did not arrive. Indeed the projections on which they were based were seen to be deeply faulty.

Healthcare was an important agenda of what came to be known as the second wave of feminism of the late 1970s. Not only did it

spread across countries, but health came to be seen as deeply political issue embedded in the structures of society and not merely a matter of scale or value-neutral technology. Women's groups in the West, now wary of the sexual revolution of the 1960s brought about primarily by the Pill, wondered if this had indeed shaken the citadels of patriarchy. They were also deeply critical of the medicalisation of women's health as the Boston Women's Health Collective's *Our Bodies Ourselves* (1971) not only became a bestseller in the US but in several other parts of the globe. Indeed, this was nothing other than a call to arms for a profound reordering of the relationship between the sexes and between women and the medical industry. The hazards of new contraceptives became an important issue, brought to the fore in the West with the controversy over the Dalkon shield. Black women's groups meanwhile took up cudgels pointing to the deeply racist ideas underlying the ideas of population control and some among them accused white feminists of being colour blind.[2] In the countries of the Third World, a range of women's groups and health groups trenchantly critiqued the family-planning programmes. The abuse of sterilisation, the incentives and disincentives that were offered in order to meet family-planning targets, all came in for critique as they were profoundly anti-women, anti-poor, and violated human rights.

This was consequent to and was also a cause of women becoming an important aspect of development. There were also calls for rethinking the role of population policies in development. At the 1974 World Conference on Population at Bucharest, the First World countries that had gone in with the understanding that family-planning programmes were at the heart of development came in for a shock as many Third World countries insisted that 'development was the best contraceptive' even as they called for a new world economic order based on equity. There were equally strident calls for looking at the issue of development through the lens of gender as the role and position of women in the world came increasingly under scrutiny. Thus the UN declared the 1980s to be the Women's Decade. At the same time, the first International Women and Health Meeting was held in Rome in 1977.

Reflecting on these various pulls and pressures, at the end of decades of campaigning, the US Supreme Court in 1973 in the historic *Roe versus Wade* case, legalized abortion. However, this decision was soon under attack and as early as in 1976 the Hyde Amendment

prohibited Medicaid funding for abortion except in the case of rape or severe illnesses. The issue of abortion has been an important one ever since then and became particularly acute in the Bush *père* years and continues to be a sensitive issue in the Bush *fils* years.

The 1970s then were exciting times in health development; indeed there was such a sense of optimism and hope that anything at all seemed possible as critiques of dominant models of health care found increasing resonance, leading to the historic declaration of Health for All by 2000 AD at Alma Ata in 1978. We shall briefly digress to this development since the current withdrawal into policies of reproductive health can only be understood in this context.

As post-colonial nations rushed to their trysts with destiny, they attempted with limited success, but with success nevertheless, to make a break with historical structures of global inequity underlying their underdevelopment. As a result of such policies as self-reliant import-substituting growth, there was a reduction in the flow of resources from the countries of the Third World to those of the First. In other words, there was a decline in the rate of exploitation of the former, as they protected themselves from, and attempted to recover from, the ravages of the first wave of globalisation, militarily imposed, that they had been victims of for centuries. This was in most cases partial and half-hearted, but nevertheless real.

There was thus a reversal of secular historical trends in food availability, in value added in production, in per capita incomes and so on. At the same time, there were efforts to provide a modicum of health, nutrition, and education. Reflecting all these changes, there were improvements in health indices as life expectations increased, the morbidity and mortality rates declined, and birth rates increased.

The nature and pattern of health sector development was, however, marked by a singular feature: the hubris of science and technology to the social problem of distribution of wealth and resources was so profoundly overwhelming that no breaks were made with the past. It was forgotten that health and disease are not merely natural occurrences, that the morbidity and mortality load in a population is distributed as unevenly as resources. It was forgotten too that health improvement in a population was less a function of medical advances than that of overall development.

Thus, as countries of the First World forgot their own health histories, and as the medical-industrial complex in these countries found

their feet, the approach to public health was both technologically determined and doctor-centered, ignoring the broader determinants of health. Further, as a result of Cold War politics, there was a paranoid fear of population growth in Third World countries, again forgetting the demographic histories of the developed world. The control of population assumed a priority not otherwise warranted.

Thus, in addition to developing curative services, technology-centred vertical programmes were launched, malaria and family planning being the most spectacular ones. In 1960, for instance, the WHO's budget for malaria eradication was greater than the rest of the WHO's budget put together: the former obtained an outlay of $18,197,726 while the total budget was $16,330,900 (Lee, 1997: 29). The family-planning programme, on its part, lurched from the extension education approach, to the IUCD approach, to the vasectomy camp approach, and finally to female sterilisation, increasingly contouring health sector development in the country (Rao, 1998a: 158). Both programmes were premised on the belief that there were technological solutions to complex epidemiological problems, a 'magic bullet' approach to public health that had no historical or indeed contemporary precedents. It bears recalling that malaria receded from Europe as living standards improved and countries completed their public health revolutions; and that following these, the birth rate declined in the face of opposition from both the state and religion and in the absence of reliable contraceptives.

These vertical programmes, given shape by international agencies, had certain singular characteristics. Planning these programmes had not always been guided by epidemiological considerations. They had often been initiated without an understanding of the nature of the diseases, their distribution, their underlying causes and inter-linkages, their behaviour over time, and indeed, often even their quantum. It is thus not surprising that these programmes not only failed to meet their goals, but also restricted the development of general health services (Banerji, 1985: 131). What they did, however, do was to provide a global market for the pharmaceutical industry, which was now a transnational one.

Towards the late 1960s it was increasingly being realised that this model of health sector development had led us down a blind alley. Both the malaria eradication programme and the family-planning programme were resounding failures (Qadeer, 2000). It was accepted that without comprehensive health care with universal coverage, and

without linking health to overall development, health improvement was bound to be chimerical.

Widespread international disillusionment with vertical programmes (Grodos and de Bethune, 1988), the recognition of the need to provide sufficient coverage to rural populations (Smith and Bryant, 1988), and the faltering integration of preventive and promotive programmes (ibid.), together contributed to the WHO–UNICEF initiative towards the declaration of the goal of 'Health for All through Primary Health Care' at Alma Ata in 1978. Indeed, at this point, the WHO saw a 'major crisis on the point of developing' in both the developed and the developing world as a result of the 'wide and deep seated error in the way health services are provided' (Newell, 1988: 903). This coincided with the growing awareness among international agencies of the failure of the family-planning approach to the problem of poverty, even as they accepted the need for integrated programmes along with the satisfaction of the minimum needs of the population in order to meet demographic goals. The World Bank and the Population Council both endorsed this 'developmentalist' perspective (Hodgson, 1988: 557). Indeed, there was such a sense of hope and optimism accompanying those rallying for 'Health for All' that there was talk of a new international economic order to arrest the continuing drain of resources from developing countries.

The late 1970s, then, were exciting times in health sector development, when it appeared that a new model of universal and comprehensive health care was being created. The entry of China into the WHO in 1973, due to 'ping pong' diplomacy by the USA, made it impossible to ignore alternative models of health care. Between the late 1950s and early 1970s, China's life expectancy, despite famine deaths, had increased from around 22 years to 46 years, a feat that had taken the Western world more than a century to achieve. With no assistance from the WHO or any other international agency, an 'underdeveloped' country with a 5th of the world's population had created an exemplary system of basic health care for its vast rural population. The human-power for this system came not from doctors trained along Western lines but from the peasantry. The problems of hunger and infection, the quintessential diseases of poverty, had been literally fought with no magic wands, but with food and employment.

The defeat of the USA in Vietnam gave a piquant new twist to Cold War politics as the Soviet Union now attempted to take a leadership role, pushing the WHO towards Alma Ata. The Soviet delegate

at the WHO stated that 'the Soviet Union was prepared to show participants what had been done over the last 50 years' (Lee, 1997: 42).

The Alma Ata Declaration of Health For All thus had a complex heritage. It promised something revolutionary for health in Third World countries as the goal of Health for All, it was evident, could only be achieved through overall and equitable development. There were other singular features of the Alma Ata declaration. For the first time, at the global level, a holistic policy was envisioned that saw health as an outcome not just of interventions in the health sector, but above all a matter of socio-economic development that it would synergistically bring about. Second, it was realised hat the issue of health sector intervention could not be compartmentalised; in other words that the whole was greater than the sum of the parts. The piecemeal approaches adopted thus far had, therefore, failed to pay dividends all too often simply because they were neither universal nor comprehensive. Third, attention was drawn to the fact that technical intervention without overall development had its limits; further that technology itself must emanate from local and national resources and must be tied to the overall patterns of diseases and deaths. These priorities had to be determined nationally and health sector development, therefore, had to be a function of these epidemiological priorities and technical choices. Finally, it was realised that these were not unattainable goals, indeed their attainability was less a function of resources than of political will. In other words, the Alma Ata Declaration drew attention to the need to address the underlying social, economic, and political causes of ill-health and diseases (Werner and Sanders, 1997).

The concept of PHC, far-reaching and indeed revolutionary, seriously questioned, if not undermined, the role of the medical–pharmaceutical industry and health bureaucracy. It is not surprising that in addition to medical professionals, a range of actors in the international health industry set out to undermine it. This was also related to the fact that there was a profound misunderstanding of PHC, especially in the West, where it was somehow understood as low-cost care of relevance to Third World countries, rather than as a profound, and rational, reordering of health care across the globe. The academic critique came principally from votaries of what was strangely, and contradictorily, called Selective Primary Health Care. The first salvo was fired by Walsh and Warren (1979). They argued, disingenuously, that while the aims of PHC were indeed laudable,

they were largely unattainable given financial and other constraints. In this context, therefore, it was more realistic to target intervention to specific diseases utilising techniques that were both low-cost and cost-effective. This was not merely academic, as this line of argument soon found purchase among many international donors (*Social Science and Medicine*, 1988) and thus national governments. Indeed, it was not long before international organisations like the UNICEF retreated from the more revolutionary position they had adopted at Alma Ata. Critics pointed out that this retreat into vertical programmes would undermine the social basis of comprehensive care, that they claimed too much for a handful of technologies, that evaluating the costs and benefits of health and disease had been carried out in too narrow an economic framework, and, above all, that they could be used to justify reductions in public finance for health care (Wisner, 1988). Indeed Newell argued: 'Selective Primary Health Care is a threat and can be thought of as a counter revolution. Rather than an alternative, it is a form of health service feudalism which is destructive. Its attractions to the professionals and to funding agencies and governments looking for short-term goals are very apparent. It has to be rejected' (Newell, 1988: 906).

But perhaps what defeated the hope and optimism of PHC was the onset of the 'decade of despair' (UNICEF, 1989: 2). For this was precisely the period when, for a complex number of reasons, the long boom of the post-War golden age of capitalism ground to a profound crisis. This period was also marked by the rise of right-wing monetarist regimes in the USA and the UK, along with the dominance of the belief in the mantras of what Hobsbawm describes as 'ultra-liberal economic theologians', whereby 'the ideological zeal of the old champions of individualism was now reinforced by the apparent failure of conventional economic policies' (Hobsbawm, 1994: 409). As the Keynesian world came increasingly under attack, that of actually existing socialism turned upside down.

The remarkable similarities between Malthusian times and the 1990s has been widely noted. Both periods were characterised by a relentless drive to create free markets, 'not by chance nor as a result of spontaneous development, but as an artefact of power and statecraft. In nineteenth century England it was the outcome of the project of classical political economy; now its is a monetarist project, to create a global market society largely unconstrained by public action' (Wuyts, 1998: 34). This new global market was to be created by a

second wave of globalisation with the imposition of structural adjustment programmes.

Hartmann notes that population control discourses obtained a new lease of life, a resurgence, in the 1990s as Cold War obsessions gave way to new definitions of security in the new uni-polar world. The consensus in the corridors of the security establishment in the US, is that population growth threatens international stability in the post-Cold War world. While it is acknowledged that economic growth and empowerment of women are necessary to reduce birth rates, vigorous family-planning measures are the 'least costly' and 'most pragmatic' means for defusing the threat to international peace. 'The American interest is clear: we need to commit our leadership and resources to a multilateral effort to drastically expand family planning services' (Carnegie Endowment, cited in Hartmann, 1993: 4). At the same time the World Bank's thinking also underwent a shift from viewing poverty alleviation as the key to fertility decline to the view that population problems cannot wait for their solution on socio-economic development. Indeed that population growth presented an obstacle to economic recovery and the 'necessity to succeed with the structural adjustment effort' (ibid.: 4).

As the structural adjustment programme would cut the excesses in the economy, so too would the family-planning programme guarantee a correspondingly lean family. Indeed the reduction in state subsidies to welfare programmes would increase the cost of supporting many children and thus persuade families to adopt family planning. 'Playing on images of excess and waste, thus the structural adjustment programme and the family planning programme would, in conjunction, streamline the social and economic corpus' of borrowing countries (Ali, 2003: 3). This would require the constitution of new kinds of families within which the notion of individual choice is paramount, calling for a shift from structural development and social equity to behavioural modification and expanded contraceptive choice.

It is thus difficult not to separate the ICPD's call for reproductive rights from the context of the new global recession. Economists hesitated to use the word 'depression' to describe this phenomenon since it brought back painful memories of the 1930s, a period that had plunged the world into the horrors of fascism and the Second World War, but the 'recession' of the 1980s was similarly widespread and deep, with equally profound social consequences. These changes took place together with the collapse of the Soviet Union and the state controlled

economies of the socialist world. They also led to a reshaping of the capitalist world, not in the direction of the new international economic order envisaged by the Third World at the time of Alma Ata but in a diametrically opposite direction. The new world order that was actually created led to a complex of changes known as globalisation, privatisation, and liberalization. We shall now turn our attention to this.

In the 1970s, following the rush of deposits in the wake of the oil price increases, private Western banks, flush with investible funds, encouraged governments in the Third World to borrow, largely to fund extensive and large-scale development projects. So acute were the problems of uninvested capital that the banks were not averse to bribing influential politicians and officials to make commitments towards these projects, many of which were otherwise unviable. Indeed it has been noted that 'commercial banks began an orgy of lending' (Gershman and Irwin, 2000: 21). The projected returns from these projects, however, failed to materialise. At the same time, interest rates were sharply put up in the USA thus markedly increasing the volume of the debts of the borrowing countries. By the early 1980s, a large number of heavily indebted countries were unable to pay back their loans. Most dramatically in August 1982,[3] Mexican leaders informed the US government that Mexico would be unable to make further payments on her international debts. This threw the government of the US into panic, fearing a rush on banks and the collapse of the international financial system should Mexico be followed by other countries.

It was at this juncture that the IMF stepped in to bail out the Northern banks by offering loans to the indebted countries to help them pay back their loans. The loans were thus primarily aimed at preventing the collapse of the commercial banks that had been profligate with their policies; they also served to involve borrowing countries in a new framework of regulations in the economy, ostensibly aimed at improving their efficiency and competitiveness in the world market and thus also help these countries to pay back the loans (George, 1990).

The initial response of the Western governments, shaped by the IMF, was that the crisis was a short-term problem. It soon became apparent that this was not the case: the economies of the borrowing countries were not rebounding, and far from attracting foreign investments, capital fled these countries. The World Bank and the IMF, pushed by their most powerful shareholders, the US, UK, and

Germany, intervened more dramatically to restructure the economies of these countries. The package announced was the Structural Adjustment Programme (SAP).

Thus the restructuring of Third World economies to ensure debt repayment began to drive economic policies in the Latin American countries and Africa in the 1980s and in Asia in the 1990s.

Right-wing economic policies, described variously as Reaganomics, Thatcherism, corporate globalisation, or monetarism, reflected an ideological commitment to unbridled market principles, ignoring the remarkable role that the state had played even in the advanced capitalist countries. One of the significant lessons of post-War economic growth had been the singular role that the state could play, and indeed needed to play, in capitalist countries to avoid recurrent periods of crisis due to falling demand. For instance, state involvement in public health had been considered critical, as state provision of public goods was also at the heart of the strategy to stabilise the economies and to increase productivity. In the new environment of the 1980s, these Keynesian policies came under attack.

The new consensus had a profoundly cynical view of the state, especially in developing countries, although neo-liberal free-market rhetoric often contrasted sharply with the actual practices of the Reagan and Thatcher governments in their own countries where the state was increasingly subsidising the rich (Gershman and Irwin, 2000). The diagnosis of the problems of poor countries was that the state played too great a role in the economy, preventing markets from acting efficiently, and breeding inefficient uncompetitive industries sheltered behind protectionist walls, thus distorting markets and prices.

Reducing the role of the state and increasing that of the market, irrespective of their social and indeed long-term economic costs, was thus at the centre of this model of therapy. This was accompanied by the triumph of the ideology of individualism, competitive wealth seeking, and unbridled consumerism among the rich. Along with the decrease of community values, this led to the undermining of public initiatives and institutions, especially those that served and protected the interests of the weak and the poor (Rao and Loewenson, 2000). Economic growth, it was maintained despite extensive evidence to the contrary, would trickle down to the less fortunate and thus result in overall development.

At the height of her economic and political power in the new unipolar world, the US found a way out of the impasse of falling rates

of profit and increasing unemployment within her shores by opening up potential markets in the Third World countries. The debt situation became the vehicle for introducing these measures brought together under the rubric of the SAP. Future loans from international financial institutions and access to donor funds and markets became linked to accepting this broad package of macro-economic policies.

The SAP measures essentially included trade liberalisation, removing the protection afforded to local industry, deregulation of the economy with few or no controls on foreign investments, abolition of price control, removal of protective barriers to the outflow of funds; cuts in government spending including the funding of social sectors, devaluation of currency ostensibly to achieve export competitiveness, deregulation of labour laws and the retrenchment of workers to make firms more efficient; public sector reform typically through privatisation, and, finally, removal in a phased manner of all social subsidies.

It was believed that by adopting this package of policies, indebted countries would not only attract foreign capital, but would also be in position to pay for them by increasing growth and by increasing the exports of goods and commodities (in particular primary commodities) they had a comparative advantage in. The free flow of funds across borders, it was believed, would facilitate this process, integrating protected economies increasingly with the global market. At the same time, removing public subsidies and cutting public spending would enable indebted countries to mobilise larger funds for investment. Providing a stimulus to the private sector by loosening regulations and controls would provide the necessary stimulus to this sector of the economy to act as an engine of growth. Above all, these measures were a fetishisation of economic growth with the issue of distribution receiving scant attention.

Deflation, liberalisation, and privatisation were applied in a uniform measure across Latin America and Africa in the 1980s. In the agricultural sector, this led to the reinforcement of colonial patterns of agricultural production, stimulating the growth of export-oriented crops at the cost of food crops. The problem at the heart of this pattern of production was that it reinforced the pre-existing international division of labour and was implemented at a time when the prices of primary commodities were the lowest in history. Indeed by 1989, prices for agricultural products were only 60 per cent of their 1970

levels (Hartmann, 1995). Thus, the more successful these countries were in increasing the volume of exports, in competition with other Third World countries exporting similar products, the less successful they were in raising foreign exchange to finance their imports. Thus many countries shifted back in time to being exporters of unprocessed raw materials and importers of manufactured goods, albeit with a sharp deterioration in the terms of trade vis-à-vis developing countries.

In the industrial sector, where developing countries had been striving to break out of colonial patterns of dependent development, the withdrawal of state support plunged many enterprises into crisis. Such units were then allowed to close, or were privatized, or handed over to transnational corporations, typically with significant losses of employment (Sparr, 1994). Just as the state reduced its commitment to critical sectors such as education and health, so also the flow of capital across borders in search of labour, raw materials, and markets, indeed the frenetic search for quick profits, typically weakened the state. Further, over this period, capital across the globe was increasingly concentrated in fewer and fewer hands with an implosion of mergers and acquisitions.

Together these policies and processes increased indebtedness, increased the rate of exploitation of wage-workers across the globe, and shifted wealth from productive to speculative sectors. The policies also led to the increase of casual, poorly paid, and insecure forms of employment. Fund cuts in education, and health also meant that already weak and under-funded systems of health, education, and food security collapsed. Together these policies increased levels of poverty in already poor countries even as a few people became richer and the middle and upper classes obtained access to manufactured products hitherto available only in the rich countries.

Gershman and Irwin note that the involvement of the World Bank and the IMF in moulding the policies of countries in Latin America, Africa, and parts of Asia expanded dramatically in the 1980s: by the end of 1991, 75 countries had received structural adjustment loans worth more than the equivalent of $41 billion (Gershman and Irwin, 2000: 11–43). At the same time, the debt of the developing countries soared from $658 billion in 1980, to $1375 billion in 1988, to $1,945 billion in 1994 (Report of the Independent Commission on Population and Quality of Life, 1996: 45).

Critiques of these policies increasingly came to be voiced even in influential circles. The UNICEF initiated a striking series of studies

that indicated that the costs of the SAP had been disproportionately borne by the poor, in particular by woman and children (Cornia et al., 1988: 1–8). What was called for was adjustment, but with a human face, in the shape of safety nets for those rendered vulnerable by the programmes of structural adjustment.

One important consequence has been commonly described as the feminisation of poverty as females increasingly had to strive to hold families together in various ways in the face of increasing pressures, chief among them being increasing poverty and insecurity. In many countries, more women entered the labour force but typically at lower wages and with inferior working conditions compared to those for men. Simultaneously, the extent of unpaid labour in households, performed largely by women, increased as public provision of basic goods and services declined. Young children, especially girls, were increasingly withdrawn from school to join the vast and grossly underpaid informal labour market or to assist in running the household. The involvement of children and adolescents in crime and delinquency increased under these circumstances. Rising food prices, along with cuts in subsidies for the poor meant that an increasing proportion of families with precarious resources were pushed under the poverty line, affecting women and girl children disproportionately. It is not surprising that studies indicate that under these conditions morbidity levels increased even as poor people were increasingly unable to access health institutions, which under the reform measures typically introduced fee for services. Given increasing levels of undernutrition, it is not surprising that infant and child mortality rates, which had hitherto shown a secular decline, either stagnated or in the case of some countries, actually increased.

The World Bank did, in the face of these challenges, make some changes as poverty reduction again figured on their agenda. These took three forms: a prescription for labour intensive growth, investing in the poor via the development of human capital—chiefly through investments in health and education, and, finally, the promotion of safety nets and targeted social programmes. In other words, there was an implicit recognition that specific programmes were necessary to protect the poor from the consequences of structural adjustment and that growth by itself does not reduce the problem of poverty. But this rethinking was seriously limited. The Commonwealth Secretariat for instance observed:

> ... any benefits women may have attained from compensatory measures have been only incidental. They have not prevented devastating setbacks in crucial areas such as maternal and child health services, basic education and training, childcare, and the provision of credit, extension and other support services to help women as producers. (Commonwealth Secretariat, 1989: 8)

More significantly, between 1990 and 1993, sub-Saharan Africa alone transferred $13.4 billion annually to its creditors, substantially more than it spent on education and health combined. From 1987 to 1993, the net transfer of resources from Africa to the IMF was $38 billion (Gershman and Irwin, 2000: 11–43).

Increasing inequalities in income, in health, and so on were also distressingly apparent in other countries that had followed similar economic trajectories. Indeed, they were also increasingly visible among the poor even in the developed countries. In a number of the developed industrial countries, mortality differentials increased sharply in parallel with widening disparities in socio-economic status (Davey-Smith and Egger, 1993). Significant reversals in health status were also observed in the newly independent states of Eastern Europe (WHO, 1998). Sharp declines in life expectancy were also recorded in countries of the former Soviet Union, involving 'a health crisis of unforeseen proportions in the Russian Federation' (Evans et al., 2001: 3).

With the collapse of the Soviet Union, the world turned upside down for the common people of Russia. Levels of unemployment and poverty rose sharply with a two-fold drop in real income and a staggering increase in income inequalities, even as the social security system and health system, perhaps already ailing, died under the shock treatment prescribed by the World Bank and the IMF. Between 1991 and 1994, life expectancy among men decreased by close to seven years, from 63.6 to 57.5 years; among women in declined close to three years from 74.4 to 71.1 years. Such a decline in life expectations in populations not at war or suffering the onslaught of the other horse of the apocalypse, famine, was historically unprecedented. Unlike China where rural areas bore the brunt of the reforms, in Russia, the cities largely paid the price. At the same time, infectious and communicable diseases, that had disappeared, rode on poverty and hunger extracting a toll. This included the innocuous childhood disease, measles. Tuberculosis and AIDS assumed epidemic proportions. A multivariate analysis revealed that labor force turnover explained a large part

of the increase in death rates. An interesting finding is that while the gender gap in mortality is considerable in all demographic and socio-economic groups, it is consistently smaller for men and women in higher socio-economic positions. In all populations, socio-economic disadvantage increased gender gaps in mortality. In other words, of great import to the concept of reproductive health, class disadvantage preceded and took a greater toll than gender disadvantage (Shkolnikov et al., 2001). More significantly, faced with a declining population, and the prospect of immigration being an anathema, the Russian government responded with pro-natal policies which are profoundly anti-women: abortions have been made almost impossible to obtain, even as the legal minimum age at marriage has been reduced to 14 with permission from local authorities and parents and to 16 without.

This issue draws strength too from the Chinese case. Reforms in China have meant an annual real increase in the GNP by 9 per cent, quadrupling the size of the economy in merely 20 years (Liu et al., 2001). Yet this has been accompanied by increasing income inequalities between regions and in sharpening health inequalities. In 1994, the prosperous coastal province of Zhejiang had a maternal mortality rate of 23.74 per 100,000 live births while the poorer inland province of Quinhai had a figure of 215.37. Further, within provinces, rural–urban differences in wealth and well being have sharpened: the IMR is higher in rural areas than in the urban areas, with a widening of the gap. A recent study of 30 of China's poorest counties found that the IMR actually increased from 50 per 1,000 live births in the late 1970s to 72 per 1,000 in the late 1980s, despite the relatively egalitarian base at which the reforms commenced. Surveys in 1987 and 1992 revealed that the proportion of stunted children in rural areas had increased. Data on the growth of Chinese children also indicate increasing disparities in height between rural and urban areas. Despite the Chinese government's commitment to gender equity, the reforms have led to an increase in gender differentials in child survival along with increased morbidity rates among females. The economic changes along with the one-child norm, since *officially* abandoned, have accentuated the gender discrimination and thus the problem of 'missing girls'. Significantly, China too embarked upon a RCH approach just when conditions were getting worse for women in China. Poignantly, as in countries like India, with the collapse of the health system, medical expenditure is emerging as a leading cause of

the impoverishment of families. Efforts at decentralisation have merely sharpened the differentials since they did away with the principle of horizontal subsidy.

In the UK, the Black Report put health inequalities squarely on the agenda, much to the discomfiture of the triumphant Thatcherites (Townsend and Davidson, 1992). This remarkable document strikingly revealed a substantial increase in mortality differentials by class. For example, the report revealed that the unskilled working class, despite an overall decrease in mortality rates, had higher mortality rates than ever before in the twentieth century. Over this period, while disease patterns changed, while technologies radically improved, and while more was spent on medical care that was accessible to the entire population of the country, what did not change were the social differentials in death rates. These inequalities in health widened sharply during the Thatcher years, along with a widening of class differentials in heights among school children. Here was evidence, again, that substantial GDP growth, accompanied by inegalitarianism, was bad for health (Drèze and Sen, 1993).

But the promise of GDP growth under SAP proved to be elusive. About a 100 countries, it was evident, had undergone economic decline. Per capita incomes in these countries were lower than they were earlier. Indeed, in Africa the average household today consumes 20 per cent less than it did 25 years ago. Many SAP-implementing countries fell from their initial debt into a debt trap wherein they had to take increasing loans merely to pay back the interest on their initial loans. Since they now received less for the products they exported, they were forced to undertake repeated devaluations and thus paid not only more for their imports but also for their debt repayment. They were thus caught in a vicious circle of low capital, borrowing, devaluation, and less capital.

It is not surprising then that these two decades have often been described as lost decades. The SAP, then, did not reduce debts, cut down levels of poverty or return countries to a path of growth. The external debt stock of developing countries increased from $616 billion in 1980 to an estimated $2.2 trillion at the end of 1997. Yet, at the same time, the flow of resources to rich countries actually increased, as indeed they were designed to. In 1960, the poorest 20 per cent of the global population received 2.3 per cent of the global income. By 1991, their share had sunk to 1.4 per cent. Today, the poorest 20 per cent receive only 1.1 per cent of the global income. The ratio of the

income of the wealthiest 20 per cent of the people to that of the poorest 20 per cent was 30 to 1 in 1960. By 1995, that ratio stood at 82 to 1. This is based on the distribution of income between rich and poor countries, but when the maldistribution of income within countries is taken into account, the richest 20 per cent of the world's people in 1990 got at least 150 times more than the poorest 20 per cent (UNDP, 1992: 34–47). Twenty per cent of the world's people who live in the highest income countries account for 86 per cent of global consumption; the poorest 20 per cent account for only 1.3 per cent of global consumption. In other words, while the world has grown incomparably richer, the wealth generated has been distributed remarkable unequally. It is thus not surprising that critics have argued that 'globalisation is really about the expansion of TNC activities to the developing world on TNC's terms' (Raghavan, 1996: 13) and that 'globalisation is proceeding largely for the benefit of the dynamic and powerful countries' (UNDP, 1997). It can also perhaps be described as a neo-colonial marriage between metropolitan financial interests and metropolitan industrial interests (Patnaik, 1999).

While it is in the context of both the retreat from PHA and the increasing marginalisation of poor countries and the poor men and women among them that we must locate the discourse on reproductive rights, there were also other factors, other discourses that came into play.

Debates on population refined some themes, sharpening them, while others were unabashedly and crudely racist. One related scarcity, security, and war and the second, the now famous IPAT equation refined ideas attributing environmental degradation to population growth, while Maurice King was unabashed in his genocidal views on withholding health care in poor countries marked by reproductive extravagance and thus population growth.

With the end of the Cold War, new concerns shaped the national security agenda of the US. One was the 'scarcity-security-conflict model', which soon became conventional wisdom in the policy enterprise linking US departments of defense, the CIA, academic institutions, private foundations, and NGOs within the environmental movement. According to the main propounder of this model, Thomas Homer-Dixon, there is a direct causal relationship between population pressure, environmentally induced scarcities, and intra-state conflict in the countries of the South. Thus political strife in Rwanda, Haiti, and Chiapas in Mexico were attributed to population induced

environmental stress and the consequent struggle for scarce resources. The Rockefeller Foundation in its report, *High Stakes: The United States, Global Population and Our Common Future*, drawing on this model, argued that 'resource scarcities, often exacerbated by population growth, undermine the quality of life, confidence in the government and threaten to destabilize many parts of the globe ... violent conflict is often the result' (cited in Hartmann, 1999: 2). It is difficult to believe that this model has obtained such attention, not to mention academic sanction, but as Hartmann observes, 'In Homer-Dixon's conservative worldview the mal-distribution of both power and resources is essentially naturalized and determined by the god of scarcity. When this god of scarcity meets the devil of racism, the result is a greening of hate' (ibid.: 11). It was of appeal to conservative elements not only with the security establishment of the US but also NGOs in the environmental movement, increasingly attracting racists and neo-fascists.[4] For one factor that united these disparate groups was the fear of immigration of 'environmental refugees' fleeing the chaos and violence they were thought to have brought upon themselves through unbridled population growth. Given what we know about the global utilisation of resources, it does not appear to be necessary to critique this model of apocalypse.[5] It is nevertheless instructive that not only is this model based on unscientific assumptions and deduces cause from association, much like neo-Malthusian arguments, it also eerily recalls the heydays of eugenics and the fears of immigration that they engendered.[6] For above all, the globalisation of the day refers to the free movement of capital, not of labour as more and more rich countries erect implacable walls against immigration from poor and dark countries. What it also ignores is that birth rates have, in fact, declined around the globe much faster than had been predicted and that the relationship between population growth and environmental degradation is mediated through a number of factors, historically determined and, therefore, contingent. Indeed even the UNFPA in its report *The State of the World's Population 1992* acknowledges that there is no correlation between degradation of the global environment, poverty, and population growth in Third World countries (UNFPA, 1992).

Closely related is the IPAT equation, put forth in the mid-1970s by Paul Ehrlich and John Holdren, that took on a new lease of life in this period. Its great appeal perhaps lies in precisely its beguiling simplicity.

The equation is as follows: I = PAT, where the impact of humans on the environment (I) is a product of the number of people (P), the amount of goods consumed per person (A), and the pollution generated by technology (T) per good consumed. Not only is the IPAT equation ludicrously simple, it is also apparently logical and internally consistent. What it does not do, however, is simply daunting: it does not reveal *who* in the P consumes *how much* of what resources utilising what technology. In other words, in a deeply polarised world, can the 1 billion poorest—who are the concern for fertility control—compare with the 1 billion in the rich countries who consume 75 per cent of all global energy and generate almost 90 per cent of ozone-depleting chlorofluorocarbons and two-thirds of carbon dioxide emissions? Should we talk not of 'population' at all but of 'effective population', the IPAT equation would be turned on its head. As Hartmann has pointed out, what the IPAT equation significantly omits 'is the question of social, economic and political power, and the systems by which current power relations are enforced. These underlie P, A and T, and the interaction between them' (Hartmann, 1993: 9). Nevertheless, environmentalists used the IPAT equation to jump on to the reproductive health bandwagon arguing that the antidote to population explosion was 'empowering women' in order to bring down birth rates (Hynes, 1999).

At the same time, in a now infamous debate initiated by Maurice King, an erstwhile supporter of PHC, it was argued that in countries that were 'demographically trapped', the life of a child may be preserved technologically in the short term, but only for a miserable and malnourished future and early death (King, 1990). In such countries, therefore, 'de-sustainable' public health technologies ought to be withheld as they merely increase man-made human years of misery. Obviously it is a sign of the times, when racism is again acceptable, indeed flourishing, that the *The Lancet* ran an editorial presenting these genocidal ideas under the title 'Nothing is Unthinkable'. There is both poignancy and irony in the fact that this was also precisely Thomas Malthus's reaction to the decline of the death rate in England. The Census Commissioner for England and Wales in his report on the 1861 Census recorded Malthus as saying: 'I feel not the slightest doubt that is the introduction of cowpox should extirpate the small pox, and yet the number of marriages continues the same, we shall find a very perceptible difference in the increased mortality of some other disease' (cited in Clark, 1968: 52). In this scheme of things

disease played a divinely ordained role in maintaining the status quo, and is hence beyond the ken of human intervention.

In the anti-women, anti-poor environment of the period, and partly as a consequence, there occurred a rise of virulent 'fundamentalisms' in various religions—Hindu, Muslim, and Christian. These are unabashedly political projects seeking to mobilise discontent and anger with the deeply divided world, a world wherein modernity has failed to deliver, where hopelessness with the state of things led to the immense appeal of these atavistic forces seeking to recreate a golden period of innocence and plenty that never existed. Thus Christian fundamentalism, as indeed among other religious groups, that dictatorship of the holy minority, finds its natural place in the neo-liberalism of the New Right today: the withdrawal into the family and the 'community' undermining the autonomy of women and reinforcing that of patriarchy (Eisenstein, 1982). There has been in a sense a complete about-turn in the politics of these groups; earlier, suspicious of 'others' and the government, they retreated into their communities and churches. Today, however, they have found a new stridency as they increasingly utilise corporate funding to influence politics and have come to command the Presidency of the US. Although the huge health and indeed financial costs of limiting women's access to abortion are unambiguously clear, across the world there has been a phenomenal growth of the anti-abortion movement, aiming to bring back restrictive laws limiting or criminalising abortion. They are nowhere as strong as in the US, where not only has funding for abortion been withdrawn in many states, but doctors and nurses performing abortions have been shot at and clinics fire-bombed or vandalised. Federal funding for abortions is prohibited, affecting in particular, poor women of colour and other ethnic minorities (Jacobson, 1990). The politics of foetal rights, indeed of privileging the rights of the foetus over that of the mother, reached its absurd limits when a Californian court in 1986 ordered the arrest of a woman on charges of medical neglect of her foetus (Doyal, 1995). The new globalisation also means that there is a globalisation of the right-to-life campaigners. Indeed it was the influence of this movement over Republican policies that saw the Reagan government enacting the global gag rule, and at the 1984 World Population Conference at Mexico city, announce that population growth was a 'neutral' phenomenon even as the government cut funds for family-planning programmes providing or promoting abortion services. Indeed the US position here was that

excessive state control of the economy was responsible to a greater degree for economic stagnation than population growth (Hodgson and Watkins, 1997). Thus, is it possible at times to have ones cake and eat it too.

The availability of new technologies--of so-called gene therapy and in vitro fertilisation (IVF), and the spectre of human cloning—have raised a host of issues of morality and ethics that has added to the fulminant strength of the right-to-lifers. Their strident stands are derived apparently from Biblical injunctions and not the more quotidian and secular concerns of what these technologies imply for the rights of mothers, of the poor, and indeed of the diseased or disabled. It is also not surprising that there is a new lease of life provided by such currents to discredited eugenics as authors increasingly do not feel ashamed to argue for instance that intelligence is inherited and indeed racially determined (Herrnstein and Murray, 1994). This is, of course, also related to attacks on the welfare state initiated by Margaret Thatcher by blaming the poor for their poverty. Rose notes, for instance, that neo-liberalism provides the perfect niche for biology-as-destiny arguments in garbled pseudo-sciences (Rose, 2001). As in Malthusian discourse, what Thatcher was doing was arguing that the poor had no moral right to claims on the state.

Not accidentally, the new 'plague' of AIDS also provided an impetus to the focus on reproduction. The onset of the AIDS pandemic came as a profound shock to the developed world that believed that infectious diseases were a thing of the past in their societies. As Rosenberg remarks:

> ... [AIDS reminds us], we have not freed ourselves from the constraints and indeterminacy of living in a web of biological relationships—not all of which we can control or predict. Viruses, like bacteria, have for countless millennia shared our planet and our bodies. (Rosenberg, 1992: 287)

Its initial association primarily with homosexuals and drug addicts seemed to suggest that it was a disease of the dregs of society, reinforcing existing prejudices of class and sexuality. But when the enormous costs of the disease to society, its seeming ability to cross barriers of class, and its mutability came to the fore, efforts were made to take stock of the disease and to control its spread in the general population. Since not very much was known about the epidemiology of the disease, one primary method of prevention was obviously sexual

continence and the use of condoms. But when the association of AIDS with other reproductive infections became apparent (evidence strongly suggests the facilitating role of genital ulcerative diseases like chancroid, syphilis, or herpes in HIV-1 transmission [de Schryver and Meheus, 1990]) it was evident that the ambit of intervention had to be broadened to reproductive health as a whole. Thus the impetus for improved management and control of STIs, and the resultant shift in focus from special treatment centres, was primarily due to the advent of HIV and AIDS (Chen et al., 1991).

The World Bank was, over this period, increasingly setting the agenda for health. World Bank lending in the health sector is thus larger than the entire budget of the WHO. Within the health sector, and especially following the publication of the influential 1993 Report *Investing in Health* (World Bank, 1993), the World Bank's policies of health sector reforms have essentially meant redefining public spending in health to an essential package of clinical services, phasing-out public subsidies especially for tertiary care. It has also urged governments to foster competition and diversity in the supply of health services. One hallmark of these reforms has been the concept of fee for services. Critics have argued that these policies have essentially been a clarion call for privatisation and a more 'cost-effective' version of selective PHC. In the process, public health was to be dismembered, diseases were to be divested from their socio-economic context, specific technology dependent programmes were to be concentrated on thus sounding the death knell to concepts of PHC (Qadeer, 1999). In other words, as the prospects for HFA receded, we saw again the dominance of the magic bullet approach to public health technology, accompanying what Renaud resonantly described as eliminating society from disease, whereby disease occurrence is ascribed to individual proclivities and failures (Renaud, 1975). As we witness increasing privatisation of health care, along with cuts in state spending on health, we see the reversal to technologically-driven vertical programmes. Thus while a holistic vision of public health has been eclipsed, the chicken of technological determinism and methodological individualism has come home to roost with a vengeance.

Implementing these have meant that it is assumed that macro-economic policies that have eroded the previous gains in health somehow cease to matter. In other words, an increasingly biological notion of the determinants of ill-health and disease in populations is turning

public health on its head. Given the overwhelming influence of the World Bank on health and population policies of borrowing countries, it is not surprising that when the World Bank made a 'paradigm shift' to reproductive health, borrowing countries were quick to follow. Thus while the onslaught of the Right provided the impetus for feminists in the West to highlight the critical importance of reproductive rights at the ICPD, it was also brought to centre stage by the concerns of the population control lobby and the World Bank to infuse a new lease of life into faltering family-planning programmes.

There was, then, a coming together of seemingly opposed groups in crafting the 'Cairo consensus'. On the one hand these was the population control establishment, composed of a wide array of actors ranging from the World Bank and Population Council to a number of NGOs, nation states, health personnel and academics (Bandarage, 1997). This group apparently realised that the demographic goal of reducing fertility could not be attained without taking into account women's ability to make decisions regarding reproduction and fertility. In other words, even for purely instrumental reasons, there had to be a change in the approach to the population issue. On the other hand were women's rights activists, feminist academics, and some health activists. Many of them undoubtedly brought to the fore First World feminist concerns; others had indeed campaigned against coercive population control programmes and policies in the Third World. They were united in opposition to fundamentalist groups from the USA and from conservative Islamic countries and the Vatican (Petchesky and Judd, 1998). It is important thus to remember, as Ravindran points out, that the demands for reproductive rights and health did not originate in Cairo and was not an idea formulated by the population control agencies or other international agencies that supported them (Ravindran, 1998). Nevertheless it is as the Cairo consensus that they cast their influential shadow.

The Cairo consensus has been described as a landmark accord, a turning point in the history of the population field, a sea-change in the way population and reproductive health are conceptualised (Haberland and Measham, 2002). More frequently it has been described as a paradigm shift in the way population and development are understood. Indeed it has been described as revolutionary (Cornwall and Welbourn, 2002).

At the international level, Cairo had been preceded, officially, by the Human Rights Conference in Iran in 1968 which emphasised

the importance of free and informed choice in contraception. The Teheran Declaration stated:

> Parents have a basic human right to determine freely and responsibly the number and spacing of their children and a right to adequate education and information in this respect. (Hardon, 1997: 3)

These were later elaborated in subsequent World Population Conferences. Both the Bucharest Conference (1974) and the Mexico Conference (1984), drawing on the Teheran documents, made specific reference to reproductive rights. The Bucharest Conference stated that this was a right of 'individuals and couples' and not merely parents. The 1984 document went further in declaring that women's right to control their own fertility 'forms an important basis for the enjoyment of other rights' (cited in Boland et al., 1994: 92). The UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), adopted by the UN in 1979 and ratified by 140 of the 159 member countries by 1995 stated:

> State parties ... shall ensure, on a basis of equality of men and women ... the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights. (Hardon, 1997: 3)

The rights of reproductive choice was prominent in Article 16 of CEDAW which requires that 'State parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations' (cited in Boland et al., 1994: 94). In a significant, albeit subtle departure from the Teheran and Bucharest declarations, the CEDAW states that men and women should have the same rights to decide on sexual and reproductive matters.

The Platform for Action of the Cairo Conference defined reproductive health as follows:

> Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to

> reproduce and the freedom to decide, if, when and how often to do so. Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. Sexual health aims to enhance life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases. (ICPD, 1995: 31)

The Cairo consensus was indeed a significant, if modest, step forward. It meant a break from the past in various manners. It signalled a move away from demographically driven population policies that 'attribute[d] poverty and environmental degradation to women's high fertility, and, in turn, women's high fertility to an absence of information and methods' (Petchesky, 1998: 2). It also challenged the 'moral arsenal' of Christian, Hindu, and Islamic fundamentalists to curtail the rights of women in the name of tradition or culture, often fraudulent and concocted. It meant further a redefining of the field of population studies that had neglected sexuality and gender roles, focusing instead largely on outcomes such as contraceptive efficacy or declines in birth rates, or, more recently, on reproductive infections (Dixon-Mueller, 1993). Above all, it provided a fillip—and sanction through an international covenant—to health groups fighting coercive population programmes in a number of countries. It was now possible for these groups to argue that these programmes violated international covenants that the government itself was signatory to.

But was this merely a 'semantic revolution' (Correa, 2000: 7)? Is feminist rhetoric being used by international population agencies to legitimise and gloss over narrow instrumentalist concerns (Correa and Petchesky, 1994)? Was it merely a 'Western' concept, lent credence by the undoubted economic and political power of the West and, therefore, to be rejected? Hartmann notes for instance that the 'new consensus' is nothing but a new strategy to obscure class, gender, and race inequalities in a grand consensus in which everyone's interests are simultaneously apparently served. 'Women, population and the environment have become formally linked, a holy trinity in the consensus cosmology' (Hartmann, 1993: 1).

It is true that reproductive health and rights cannot have a universal, trans-historical meaning, or indeed relevance, in a world differentiated

by nationality, class, ethnicity, religion, race, and so on (Bandarage, 1997). Women's ability to make reproductive decisions is mediated by multiple and complex processes by which class, caste, religion, the family, in short the institutions of patriarchy, interact with and are acted upon by the state and international structures. That is to say, there is a need to integrate the politics of the body into a larger framework that emphasises the transformation of the state, social, demographic, and economic development policies (Petchesky, 1998).

Thus women's control over their bodies, over reproduction, is an issue of power, both between the sexes and among various layers of society. Differentiation among women also has a profound implication for the ability to exercise such control. A range of practices, laws, values, and institutions provide the hegemonic basis for patriarchy. The challenge of reproductive rights is thus about challenging both the ideology and practices which allow others to control women's bodies. Correa and Petchesky thus argue that notions of power and rights to resources are intrinsically imbricated in the discourse on reproductive health. Thus the struggle for reproductive health is nothing less than the 'democratic transformation of societies to abolish gender, class, racial and ethnic injustice' (Correa and Petchesky, 1994: 107). In other words, reproductive health is an important part of a broader conceptualisation of rights, of a good world. As Petchesky puts it:

> As part of collective feminist efforts to reclaim property in our bodies, we must redefine all essential health care and services ... we must reconnect our self-ownership to our right to common resources. Of course, in a world where the language of social need and common property is rapidly disappearing in the universal babel of the market (which so easily co-opts the idea of individual choice), this would almost mean turning the world upside down. The language of reproductive freedom is still burdened with 300 years of the dominant Euro-American model of dichotomisation between self and community, body and society. But language has as much resilience and power to transform as do the social movements that deploy it and the politics that re-invent it. (Petchesky, 1995: 406)

But is reproductive health actually about turning the world upside down? Or is claiming too much for the concept, important though it is? Is it a case of spinning a strong argument from insubstantial threads? Can the concept carry the burden of transforming the world? Turning the world upside down was, of course, what the struggles of

workers, the dispossessed, sought to do in times past when *liberté*, *fraternité*, and *egalité* were cries echoing across borders. But in a world of liberalisation, privatisation, and globalisation, a world in which workers were up against a wall, increasingly joining the ranks of the surplus population, could a call to arms for reproductive rights help them storm the metaphorical Bastille? Finally, is there a profound confusion between cause and consequence? How then does one reconcile the position of the Government of Eritrea at Cairo?

The Government of Eritrea issued a statement that was astonishing in scope, revealing a vision that was rare for the times and threw the gauntlet back to the West and indeed those rallying for reproductive rights. It was not arguing that reproductive rights were not an important goal, nor was it arguing that this goal was not desirable, nor unattainable. Nevertheless its position was that given existing conditions, there were prior claims to justice, to equity, and to rights that obtained moral and political precedence. It thus warrants quoting, even if at length.

> In the case of Africa in particular, it is debatable whether reduced population growth will mitigate its marginalisation in the world economic order and accelerate its development. Africa enjoys, on the whole, considerable camparative advantages in terms of territorial expanse and natural endowments. Its population density—even taking into account current rates of fertility—is and will remain low in relative terms for the foreseeable future. The appalling poverty and deprivation that stalk the continent are not certainly due to overpopulation and they will not be eradicated if family planning were to be introduced through attractive palliatives and public education programmes. The scourge of ethnic conflicts, massive internal and external population displacement and widespread deprivation will not be healed by the most prudent and comprehensive demographic policy.
>
> In the event, what is required is a much bolder and holistic approach that addresses and tackles the real causes of underdevelopment. Existing imbalances in the terms of international trade must be adjusted to promote rapid and sustainable development in the countries that are lagging behind and in which the economic gap is widening .... Furthermore, it is a matter of historical reality that population stabilization is likely to be achieved as a byproduct of rather than an antecedent to overall development .... The various programmes associated with family planning, and especially the social safety nets for the elderly, public education programmes for adolescents, empowerment

> of women, etc. cannot be implemented on a sustainable basis from external funding. Internal development would be essential and indeed a prerequisite for an undertaking of this scale. In brief, the answer does not lie in a compartmentalized and piecemeal approach but on a comprehensive and innovative approach to the crucial issue of development in the Third World. (Government of Eritrea, cited in Hartmann, 1995: 152)

Echoing, in a sense, this more comprehensive position, the Committee for Women, Population, and Environment (CWPE), a feminist group fighting for an alternative understanding of the issues relating to the population question, which indeed seeks to turn the world upside down, argued:

> Since such conferences are set within a framework of liberalization, privatization, and market supremacy ... injecting a feminist and environmental impulse is a contradictory move, because this paradigm runs counter to feminist and environmental values and principles. Moreover, we are troubled by the way in which this 'consensus' was orchestrated and financed by a small group of actors. We are concerned with how population control organisations were adopting and adapting the language of women's rights, without fundamentally changing their programmes and policies. CWPE believes that structural adjustment, 'free trade', militarism, consumerism, and corporate pollution were not adequately addressed in Cairo. It is ... beyond the confines of orchestrated consensus that we see the real political space from which positive visions of social, economic and environmental justice emerge. (Silliman, 1999: xii)

But as in the case of PHC, bringing 'pragmatically' forth a seriously compromised SPHC, even the RHC proposed at the ICPD was waiting to be reshaped. Arguing that the vision of a good social and economic policy and a just population policy, despite being desirable are not pragmatic, Jain and Bruce of the Population Council suggest a transitional strategy that they name the '1994 strategy'. This 'focuses primarily on fertility reduction', 'paying attention to those aspects of reproductive health that interact directly with the avoidance of unwanted fertility' (Jain and Bruce, 1994: 195). RHC, in this view, was limited to safe abortions, treatment of pre-existing conditions, such as RTIs, that would make particular contraceptive methods unacceptable, and the treatment of contraceptive side effects. Was this, then, what all the storm and thunder of reproductive rights

was about—making contraceptives more acceptable? For, of course, there was a new generation of contraceptives—injectables, implants, and so on, waiting for the cornucopia of the markets of Third World women's bodies.

Critics also argued that in the agenda of rights of the ICPD, reproductive choice refered to the plethora of contraceptive devices that a 'free' woman is supposed to be 'empowered' to choose from. In other words, that what was being attempted was to create a 'rational', utility maximising consumer in the contraceptive market place produced by the reproductive technology industry of the West. It has been noted that in the era of reproductive technologies, the concept of choice is reduced to consumption that fosters a private enterprise in women's bodies (Raymond, 1996). Thus, as feminist discourse is co-opted by development jargon, reproductive rights are divested from rights to food, employment, water, health care, and security of children's lives.

There was, of course, no original sin committed at Cairo when liberal feminists, predominantly from the West, went into alliance with the neo-Malthusian population control establishment. Indeed it was precisely this relationship that had spawned the global population control movement in the 1950s. However, during the intervening years, there had been a critical distancing. The fact that a section of feminists, referred to by Hodgson and Watkins as reproductive health feminists, were now willing to be fellow travellers with the World Bank, along with the population control establishment, however, was entirely new (Hodgson and Watkins, 1997). Was this a marriage of multinational-feminisms with international debt?

The new alliance, as has been noted earlier, had been initiated by feminists in the mid-1980s. The International Women's Health Coalition (IWHC), started with neo-Malthusian funding (it was funded by the Population Crisis Committee), was one of the leading lights, along with the Women's Environmental and Development Organisation (WEDO) (ibid.).

As Hodgson and Watkins note:

> Ruth Dixon-Mueller and others (Sen, Germain and Chen) constructed an elaborate and finely aligned 'feminist population policy' within which feminist objectives were congruent with the interests of the Neo-Malthusian movement ... with three important formulations. First, population stabilization was presented as a desirable ultimate goal ....

> Second, national programmes were justified in terms of individual human rights ... and third, the empowerment of women was presented as a prerequisite for enduring low fertility. (Hodgson and Watkins, 1997: 503)

Thus the largely American, bourgeoise feminist agenda was what shaped the 'consensus' at Cairo, if indeed consensus it was. Indeed as Sadik disarmingly noted: 'it was American leadership above all which drove the Cairo process along' (Nafees Sadik cited in ibid.: 49). Rechristening family-planning programmes as reproductive health programmes, and population control programmes as gender equity programmes, provided a politically correct rationale, a new lease of life to discredited programmes. It was indeed a case of new wine in old bottles.

It has been argued by other feminists that there can be no such thing as a 'feminist population policy', that the Cairo consensus merely replaced population control with 'population stabilization', that it paid little attention to neo-liberal macroeconomic forces profoundly shaping the health of women worldwide, and particularly in the developing countries, and, finally, that the price paid for the consensus was too high (WGNRR, forthcoming).

As if in answer to these questions the World Bank produced a policy document entitled *India' s Family Welfare Programme: Towards a Reproductive and Child Health Approach* (Measham and Heaver, 1995). Having paid obeisance to the concept of reproductive health and the transformation to India's family-planning programme this would harbinger, the World Bank argued:

> The new consensus recognizes that an important goal of reproductive health programs should be to reduce unwanted fertility safely, thereby responding to the needs of individuals for high quality services, as well as to *demographic objectives.* (emphasis added) (World Bank, 1993: 14)

Thus was a mountain of hope and optimism transformed into a lowly molehill. The very heart of the idea of reproductive health mooted by feminists—that there be no overriding demographic goals—was torn out in this avatar of reproductive health. In this transformation, 'the agenda of reproductive health is seen as a method of attaining demographic objectives set by faceless financial institutions and governments' (Sengupta, 1998: 34).

Once this conceptual revisionism was achieved, the World Bank—which actually used the discredited phrases 'population explosion' and 'control of population'—set out all too familiar strategies. What

is remarkable about this document is the weaving in of the same old concerns, albeit in the light of the ICPD.

> FWP could ... offer panchayats financial incentives to take reproductive and child health initiatives. (Sengupta, 1998: 39)

> Targets based on micro-level planning suiting the local specific needs may, however, continue to be fixed for monitoring of the program. (ibid.: 50)

> An innovative package of incentives/disincentives be formulated with emphasis on community based incentives and social security measures for individuals adopting the small family norm. The community based incentives would be linked to various benefits being made available to the public under different socio-economic development plans of the government. (ibid.)

> No more incentive to government employees will be considered. A suitable package of disincentives will be developed for this section of the society for adoption by the state governments as well. It will also be recommended to the employers in the organized sector. (ibid.)

> In order to give a wider choice of contraceptives to the acceptors, new contraceptives such as Norplant-6 and injectables shall be introduced under the program, initially under controlled conditions and gradually on a wider scale. (ibid.: 51)

Further embellishments are, of course, for a greater role for the private and NGO sectors, and, in an increasingly communal atmosphere, 'religious leaders at different levels' (ibid.: 48). The bottom line, as they say is that 'de-linking of programmes from demographic objectives does not imply that slowing of population growth should cease to be a goal of the population policy' (ibid.: 58).

It has been noted that the new reincarnation of old concerns with population control under the rubric of reproductive rights does not camouflage the essential concerns of both the World Bank and private funding agencies from the West. This is evident from the financial allocations envisaged at the ICPD: $10.2 billion on family planning, $5 billion on reproductive health, and $1.3 billion on HIV/AIDS and other STDs by the year 2000 (Bandarage, 1997).

A fascinating study of the discourse of reproductive rights in India, and how it translates into policy, noted that although there

was recognition and commitment at the policy level to a 'paradigm shift', this was envisaged through the lens of the ongoing marketisation and reforms of the health sector (Kumar, 2004). Based on a study of documents and field interviews, Kumar concluded:

> Even as this discourse of universal reproductive health was accepted, the discussion of the basic feminist concepts that founded the discourse of reproductive health—such as rights, choices and empowerment—was transformed to suit the fundamental tenets of neo-liberalism.
>
> ... reproductive ability becomes a currency of the market ... since for a majority of people, this linking of the private and public actually limits their access to health. (Kumar, 2004: 237)

Kumar argues that the blurring of the lines between 'client' rights and citizens rights, leads to a restatement of women as bearers of reproduction with the state's curtailment of its role as an agent of equity and social justice.[7] When overwhelming evidence around the globe indicates that neo-liberalism has fundamentally added to the burdens borne by women, what the policy seeks to do is to transfer the responsibility of reproduction, of social responsibility, shared by the state, the family, and the market primarily to the family, that is, women and the market.

> It is clear that the current moment of restructuring can be viewed as a concerted discursive and political struggle around the very meaning of the public and private. The proponents of globalisation seek radically to shrink the public—the realm of political negotiation—and at the same time, expand and reassert the autonomy of the private sector and the private sphere. (Brodie, cited in Kumar, 2004: 221)

Thus the doctrine of the day turned the feminists' slogan that the personal is political on its head. It is, therefore, not surprising that expressions of disquiet, dismay, and indeed anger were soon forthcoming.

In response to the Indian government's country paper at the Fourth World Conference of Women at Beijing in 1995, seven all-India women's organisations prepared an alternative document wherein the ICPD came in for stringent criticism.

> The slogan of sisterhood needs to be placed in the contemporary international situation when the so-called developed first world, led by the USA, wants to impose its agenda on the rest of the world in the name

> of globalisation ... the direct impact was seen in the recent Conference at Cairo ... where the agendas of the G-7 group were pushed through and issues concerning Third World women were left unaddressed. For instance in Cairo the issue of abortion dominated the proceedings. The representatives of million of Third World women in Cairo hoped, while supporting the struggles of Western women for their right to abortion, at least some attention would be paid to their experience. Instead they did not get the support of women representing the First World.
>
> We strongly believe that where the inequality of nations is increasing, where the development of the First World is in direct proportion to the underdevelopment and exploitation of the Third World, the slogan of sisterhood would mean to protect the interests of poor women in the Third World and to strengthen the global struggle against new forms of colonialism. (ICPD, 1995: 36)

As if echoing this, a leading feminist from Latin America wrote that the fight against globalisation and what it does to women, the fight for democracy and equality, obtains an impetus from the struggle to survive for women in the South, while for women in the North, the impetus is from ethics since 'their welfare and prosperity is built upon the backs of the women in poorer countries, as well as the degradation of work and the environment the world over' (Rosenberg, 2003: 1).

Arguing that issues of development of poor countries in the new global order received short shrift at the ICPD, it was also argued that the ICPD did not take adequate note of processes that governed health in Third World countries, which, in the current global scenario were working fundamentally against the interest of the Third World. The alternative document notes that: 'women's health should not be subordinated to population goals nor restricted to reproductive matters' (ICPD, 1995: 33).

This anxiety and unease, if not suspicion, with the concept of reproductive health emanating internationally, stems from several factors. It has been suggested that it masks racist and eugenic population control programmes behind a feminist face (Hartmann, 1998: 6). It has also been observed that 'debates being actively promoted today twist the very premises and values on which the women's movement has been based. Terms like empowerment, choice, reproductive freedom etc., are being appropriated by forces inimical to the goals of the women's movement' (Agnihotri and Mazumdar, 1995: 1869). Further, the agenda, which marginalised issues of equity and

development of developing countries, equally marginalised other important health concerns of these countries. Even as the health implications of larger macroeconomic changes were proving extremely deleterious to women's health, the focus on reproductive health seemed seriously misplaced. As Qadeer noted, 'The ICPD converted women's health into issues of safe abortion and reproductive rights alone; it marginalised issues of comprehensive Primary Health Care and social security' both of which are under attack in the new world order (Qadeer, 1995: 117). It bears recall also that the scandal of chemical sterilisation of women in India with quinacrine was carried out under the rhetoric of both choice and reproductive rights till the Supreme Court stepped in to issue a ban (Rao, 1998b).

Krishnaraj notes that the establishment now adduces the argument that given certain enabling conditions—primarily education and health, it is assumed that there is an automatic improvement in women's autonomy, which in turn leads to lower fertility. This appears not only pragmatic, commonsensical, but also eminently pro-woman. However, these processes are neither simple nor linear. The issue, of course, as the famous case of Kerala shows us, is that fertility reduction can indeed take place without other conditions—which would, in fact, 'empower' women—ever changing (Krishnaraj, 1998). Thus while women's autonomy may help reduce fertility, reduction in fertility does not necessarily imply any improvement in women's power or status. Indicators such as the sexual division of labour, access to resources, control over incomes, or indeed even access to education and income, may well remain unchanged, despite control over reproduction. In a society where the unit of production is still the family/household, where practices of marriage and birth are family-ordained, where women's lives are deeply embedded in community, reproductive rights are also difficult to translate operationally. For instance, in India women's rights to property are deeply curtailed by personal laws defined by religion. While Hindu fundamentalists point to the anti-women nature of Islamic personal laws, which they would want altered, the Hindu personal laws are also anti-women (Agnes, 1996). Changing these is simply not on the agenda in India with the right-wing holding political power.

But how valid is the approach epidemiologically? Does the reproductive ill-health and disease load represent what ought to be considered priority concerns in public health? In a trenchant critique, Qadeer has argued that:

> Despite all the emphasis on 'empowerment' and 'enabling conditions', the concept of reproductive health has derived heavily from the notions of the biological vulnerability of women and the concept of life-cycle. This has brought about a subtle shift, transforming the social processes of bearing and rearing children into essentially biological events. The notion of life cycle compartmentalises women's lives, creates artificial disjunctures and places bio-demographic aspects above class and gender differences on health. Worse, it imbues women with the instinctive and mindless existence of vertebrates, de-emphasising their power to intelligently act upon and transform their own environment. (Qadeer, 1998: 2677)

International funding has meant that a plethora of NGOs have moved into research on reproductive health, giving the issue a sense of urgency and priority not otherwise warranted. Examining data on mortality among women, Qadeer argues that the reproductive health approach is epidemiologically seriously misplaced. The largest chunk of deaths occurs in the pre-reproductive age group. Deaths due to causes associated with reproduction constitute 2.1–2.9 per cent of all female deaths. In all age groups within the reproductive years, communicable diseases constitute the highest proportion of deaths, more than thrice that due to causes associated with reproduction. What is more worrying is that there is rising trend of deaths due to communicable diseases among women in the reproductive age group. As the All-India Survey of Causes of Death (Rural) for the year 1992 reveals, among the causes of maternal deaths, anaemia and puerperal sepsis together account for the largest proportion of deaths, 31 per cent, followed by bleeding of pregnancy and puerperium—largely due to anaemia—which accounts for 25.6 per cent of deaths (GOI, 1992). While deaths due to anaemia in pregnancy is appallingly high, it is nevertheless the case that the proportion of non-pregnant women who die due to anaemia is several times higher than the proportion of pregnant women who die due to anaemia. Further, although deaths among pregnant women with anaemia has declined, although not substantially, deaths among non-pregnant women with anaemia, shows a rising trend. This points to the serious limitation of concentrating on women only when they are pregnant. Further, given that the levels of under-nutrition in the population are so extraordinarily high, and also given that the proportion of the population receiving less than the recommended daily allowance of calories has been estimated to have increased from 65.8 per cent in 1987–88 to 70 per cent in

1993–94 (Panchamukhi, 2000), it is not surprising to find this reflected in a rising prevalence of deaths due to anaemia. In other words, given the overall health situation among women, dominated by communicable diseases, anaemia and under-nutrition, to concentrate on reproductive health is to utterly miss the woods for the trees.

But this scenario is not confined to India alone. Bhattarai points out that a study in Nepal on maternal deaths (which means, of course, that we do not know the quantum of the deaths among women due to non-maternal causes), found that out of 640 deaths, 132 were due to causes identified as due to reproduction (Bhattarai, 2002). In other words, deaths from non-reproductive causes far outweigh deaths from reproductive ones even among maternal deaths. A shocking 13 per cent of these deaths were, in fact, due to suicide. The deaths were largely among poor women, suffering poverty, hunger, and the diseases of deprivation. It is true that it could be argued that had these women had access to contraception, they might not have been driven to suicide, assuming that they were driven to suicide by their pregnancy. But on the other hand, if reducing maternal deaths among women is the priority, clearly then the focus should not be on contraception but on poverty, nutrition, and availability of health services.

It has been argued that the focus on reproductive mortality has been seriously misplaced since women in reproductive ages suffer huge, and unquantified, morbidities. Reference is then usually made to some studies that have been hugely influential (Bang et al., 1989). It is, however, not legitimate methodologically to utilise morbidity data to the exclusion of mortality. To state that reproductive morbidities are high, even though it may be true, is to mis-state epidemiological priorities since they pertain to surviving populations, which elide morbidities that have already taken a toll (Rao, 2000). Further, in most studies on reproductive morbidities there is a conflation between symptoms and disease, which is not valid (Rao, 1997). The symptom of menorrhagia, for instance, can be caused by a variety of both reproductive and non-reproductive causes. Data on the prevalence of menorrhagia thus would not provide an estimate of what constitutes reproductive morbidity. Similarly, the all-encompassing category of white discharge confabulates the natural with the pathological and the infective with that caused by anaemias and under-nutrition (Rao, 2000).

A review of studies on reproductive morbidities notes the astonishingly wide variation in the study findings in the country and concludes that much of this could be due to widely varying sampling designs and diagnostic procedures. The review also points to selection bias, variable reference periods, as well as lack of standardisation in clinical definitions and criteria for RTIs. The review concludes that there are low levels of correspondence between the frequently used modes of identifying RTIs and thus difficulties in obtaining a valid and reliable idea of the prevalence of the problem of reproductive morbidity (Mamdani, 1999). What constitutes reproductive morbidity is further confounded by the absurd inclusion of nutrition in the domain of reproductive health (Jeejabhoy and Rao, 1995). By the same logic, ignoring the fundamentals of what constitutes a cause, the Bhopal gas disaster also can be termed a reproductive health issue since it had manifest reproductive consequences.

This is not, of course, to argue that reproductive health is a non-issue, but simply to put it in a public health perspective. For public health is, above all, concerned with the total population, and any claim to priority can only be relational. Perhaps what has occurred is that anxious to get on to the reproductive health bandwagon, far too many people claimed far too much for the concept. In other words, a case of someone who protesteth too much! But what is equally clear is that the ICPD represents, then, a retreat from the vision of HFA: under the rhetoric of reproductive rights, the rights of the vast majority of women to access to resources, the most basic determinant of health, are being denied. Reproductive rights, reified and taken out of context, fits in well with the neo-liberal agenda of the day.

NOTES

1. Pat Barker's novel *The Eye in the Door* (1994) Penguin, London, captures, in an aside, quite brilliantly the liberatory effects of employment and wages among women, and how their spouses in the labour movement watched with dismay, if not anger, the new shape this gave to their marriages and families. Would they want to go to the pubs with their mates asked a disgruntled husband, himself returning from a pub with his mates!

2. Marsha J. Tyson Darling notes that racism and sexism were both institutionalised in the 'science' of eugenics (Tyson, 1999).
3. So dramatic indeed was Mexico's announcement that the phrase 'debt crisis' is usually associated with this announcement and this period.
4. This has also led to a marriage between fascist anti-immigration groups and environmentalists in calling for population control in Third World countries. This was the logic adduced for the introduction of quinacrine sterilisation in Third World countries although the method, known to be toxic, had not been approved for use on humans.
5. That population growth in the developing world can be a threat to US interests is, of course, an old concern. However, the scarcity–conflict model perhaps was only one factor to propel increasing military expenditure even after the demise of the 'evil empire'. It's estimated that the world's military constitutes the largest polluter on earth, the US of course contributing disproportionately. The Pentagon is the world's largest consumer of energy and the US military accounts for 5–10 per cent of ozone depletion. Of the global military spending the share between the developed world and the developing was 80:20. The wealthiest 20 per cent of the world harbours 80 per cent of the world's nuclear, chemical, and biological weapons.
6. The Ehrlichs wrote: 'The United States faces very serious and complex problems with immigrants from developing countries. The nation has traditionally said that it welcomed the "poor and downtrodden" of the world, but unhappily the "poor and downtrodden" are increasing their numbers by 80 million a year. Many of these, of course, would like to come to the United States or other rich countries, and acquire the standard of living of the average American, in the process greatly increasing their use of Earth's resources and abuse of its life support systems' (Ehrlich and Ehrlich, 1990: Biblio).
7. In more than symbolic change, patients, clients, and women are now stake-holders, a term which had more than a metaphorical resonance with the term share-holders!

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5

INTO THE 1990s: OLD WINE IN NEW BOTTLES?

Over the years while concerns about family planning contoured health sector development, by the late 1980s and early 1990s it was increasingly, albeit reluctantly, being realised that the programme—one of the largest public health initiatives in the world—had reached a dead end (*EPW*, 1989: 704). Partly as a result of this realisation, partly as a consequence of the pressure generated by women's groups and health groups in the country calling for a radical reconsideration of the programme, and in part in preparation for the third decennial International Conference on Population and Development (ICPD) at Cairo in 1994, the National Development Committee appointed a committee on population under the chairmanship of K. Karunakaran, the Chief Minister of Kerala in 1991. The report of the Karunakaran Committee recommended that a National Population Policy should be formulated by the government and endorsed by the Parliament. The Government of India, therefore, appointed an Expert Group to chart out a new population policy.

In a memorandum to the Expert Group, women's groups pointed out:

> ... that a population policy cannot, and should not, be reduced to one of demographic control only ... for unfortunately today, women's reproductive capacity is being projected as the major threat to India's survival. Population functionaries regard women as inanimate beings whose desperate need for safe contraception can be used to force on them either sterilisation with inadequate follow-up, or unsafe and inadequately tested contraceptive technologies with no thought to their health. (CWDS, 1997: 6)

The memorandum impressed upon the Expert Group the need for 'a firm position in protecting the democratic and human rights of millions of women in this country, whose poverty, powerlessness and lack of access to information and services make them victims not only of frequent pregnancies but also of unscrupulous measures at demographic control' (CWDS, 1997: 8). The women's groups pointed out that the following measures were considered non-negotiables:

(*a*) no quantitative targets, overt or covert;
(*b*) no incentives/disincentives that seek to erode women's basic human or constitutional rights;
(*c*) no invasive hormonal technology until the quality of health care services has improved to provide the necessary monitoring;
(*d*) contraceptive responsibility and contraceptive investment to be equally shared by, and on, men and women; and
(*e*) full information on all side effects, need for after-care/monitoring, etc., on all contraceptives to be made available to all recipients. There may be a need for some penal provision for failure to do so (ibid.: 9).

In another, more detailed, memorandum to the Expert Committee, it was pointed out that that the government's population policy so far 'had been one of fertility control, pursued relentlessly, and at times coercively, through three decades, bringing disrepute to the family planning programme, compromising women's health, and accelerating the already declining sex ratio' (ibid.: 20). Pointing out that there should be an examination of the links between macroeconomic policies and health and population policies, the memorandum noted:

> One important aspect of the present policies is the reduction in real allocations to essential services, which include the public distribution system and access to food, health, education, etc. The privatization of health services and charging of user fees in government hospitals are going to further worsen the already fragile health profile of India's poor. Our experience indicates that the fast deteriorating position of women's health, indicated by malnutrition, anaemia, increased vulnerability to illness etc., is directly related to increased levels of poverty, lack of access to primary health services and not primarily to maternity related problems as perceived by official analysts. In this context, we consider the equation of health with family planning to

> be nothing short of criminal. The very fact that successive Five Year Plans have increased allocation and attention to family planning at the cost of basic health services to the extent of the former exceeding the latter in the Seventh Plan should make our point clear. (CWDS, 1997: 22)

Pointing out that evidence indicated that levels of child labour, particularly of girl children, was increasing, and the vast body of literature which identifies the status of women as a crucial factor in influencing demographic trends, the groups drew attention to the shocking increase in female infanticide and in sex determination tests followed by abortion of female fetuses. This, they argued, indicated the need to tackle the roots of women's inequality without which demographic goals themselves would have a disastrous impact. The government's priorities were indicated, for instance, with the agreement signed with the USAID in September 1992 relating to fertility control of women in Uttar Pradesh. This state has one of the 'worst indicators of women's status and of child health, and yet the measures suggested include hormonal implant with a grant of 385 million dollar grant over a 10 year period. The question then is not just the need for easy access to contraceptives, but to safe contraceptives. A choice which includes contraceptives unsuitable for use in India is no choice at all' (ibid.: 23).

What is perhaps important to recognise is that many of the elements of the Cairo 'paradigm shift' were, in fact, highlighted well before the Cairo Conference by women's groups in the country. What they also did was to paint a much larger picture, going well beyond issues related to reproductive rights. These were necessary conditions to realise any measure of empowerment of women. While they emphasised the importance of access to safe contraceptives, they also highlighted the more fundamental importance of enabling factors: health, incomes, employment, and indeed public action. But in the winds blowing across the world, such concerns hardly influenced the deliberations of the Expert Group. Indeed they hardly found resonance in Cairo.

The report of the Expert Group, commonly known as the Swaminathan Committee Report, proclaimed a policy that it described as pro-poor, pro-nature, and pro-women. The Committee took note of the huge socio-economic and demographic diversities in the country, and utilising the opportunity provided by the Constitutional Amendment towards the establishment of the Panchayati Raj Act,

sought to draft a population policy to 'think, plan and act locally and support nationally ... to achieving a population policy driven by people's perceived needs' (GOI, 1994: 3). The Committee's recommendations came in for such flack that even some of the positive aspects of the Report got lost in the heat and dust it raised.

First, with reference to the programme itself, the Committee unequivocally recommended 'the abandonment' of targets for specific contraceptive methods, keeping in mind 'the urgent need for improving the quality of services' (ibid.: 12). Further, the committee recommended that incentives in cash or kind for the acceptors of contraceptives as well as 'motivators' and service providers be discontinued.

What they also suggested was a veritable departmental revolution: the committee recomended that the MCH and family planning services to be merged with the health department to 'promote a concern for total health' (ibid.: 11). This would bring back a concern that had been expressed earlier in India in the Kartar Singh Committee Report and was at the heart of Alma Ata: the need for disbanding 'vertical' programmes. These vertical programmes, given shape by international agencies, were not only more expensive, but have historically proven to be much less effective than visualised. What is significant is that many of these programmes, with the exception of tuberculosis eradication programme, had been initiated without an understanding of the quantum of the problem, its distribution, its behaviour over time, and inter-linkages, simply because a technology effective against a disease had been discovered.

Finally, given the socio-economic and demographic diversities in the country the Committee called for 'bottom–up' planning in the form of PRI preparing their own 'socio-demographic charters', supported in its implementation by the higher levels. Although this was indeed revolutionary, this recommendation was swamped by certain other organisational changes suggested, namely, the contradictory centralisation implicit in the suggestion towards the establishment of a new organisation outside the Ministry of Health and Family Welfare, namely, the Population and Social Development Commission.

The Swaminathan Committee must surely have been surprised, if not shocked, by the intensity of the outrage that the Report elicited. Women's groups and health groups made it abundantly clear that they rejected the fundamental, neo-Malthusian understanding of the relationship between population and resources underlying the Committee's report. Thus Geeta and Swaminthan note:

> ... [while the Report] lays great stress on north-south inequality, it is reluctant to address the growing economic disparity within the country and the long-term ill effects of new and evolving economic policy which is certainly not pro-poor, pro-environment or pro-women .... India's development has failed to create social and economic conditions that favour fertility decline. Skewed and unequal land distribution patterns, uneven industrial growth, growing unemployment and underemployment, in short the structural inequality that underpins our economic system and the social inequality that marks our society are factors that the authors of the policy fail ... to integrate. (Geeta and Swaminathan, 1994: 2470)

It is true that the Report was concerned with the neglect of the girl child, the higher levels of child mortality among females as compared to males, the persistence of female child labour, the declining child sex ratios, the persistence of high infant and maternal mortality rates. Indeed they recognised the need for necessary changes in inheritance laws for promoting gender equity. But was this merely meant for 'correcting gender imbalance in the acceptance of contraceptives' (GOI, 1994: 3)?

The Committee came in for widespread criticism especially with reference to three issues. The first was that while the Report explicitly ruled out incentives, disincentives were proposed that could only be described as anti-democratic and indeed anti-women and anti-poor. This related to the adoption of a two child norm in order to be eligible for recruitment and promotion in government jobs. Further, following the example of Haryana and Rajasthan, the Report proposed to debar persons with more than two living children from contesting elections in panchayats. This, of course, was contrary to the moves made to empower women by reserving seats for them in panchayats; it also was at variance with the Committee's own commitment to democracy, indeed to deepening it through decentralisation. It need hardly be pointed out that Rajasthan and Haryana are among those states with the worst record of anti-female practices, from widow immolation to sex selective abortion of female fetuses. But what is extremely interesting is that the chair of the Committee himself subsequently wrote in a newspaper article that 'I personally reject the legitimacy of any legislation that prevents a person from standing for election at any level on the basis of the number of children that she or he has' (Swaminathan, 1994: 44, cited in CWDS, 1997). But whatever his personal opinion, the damage had been done as subsequent policies all bear this dubious imprimatur.

On the other hand, Pravin Visaria, another member of the Expert Group, observed that 'the argument that this would adversely affect the interests of women or the disadvantaged sections of society does not seem convincing, particularly in a setting when people themselves have realized the need to regulate family size' (Visaria, 2002a: 14). Visaria, however, sadly noted how stubborn feminists were in their 'vociferous opposition to this Bill'. Was this perhaps yet another indication of bemoaning an 'overdose' of democracy?

Yet another manifestation of the tendency to slip into anti-democratic moves was the recommendation that the freezing of seats in Parliament till the year 2001, on the basis of the 1971 Census, enacted as part of the infamous population policy of the Emergency period, was to be retained and indeed extended up to 2011. This meant, of course, that the states of northern India, lagging behind in demographic transition for a variety of reasons, would not be proportionately represented in Parliament. In other words, the proposal to debar persons with more than two children from contesting elections to the panchayats, was not in a sense a flash in the pan, but a more fundamental anti-democratic world view. Here again was an expression of the tired and familiar argument that we noted in an earlier chapter: family planning has failed, it must be made to succeed at whatever cost; indeed this was seen as a move revealing 'strong political commitment' (GOI, 1996: 10).

The second issue which invited widespread criticism was the Committee's observation that it 'has to be recognized that no medication, including that for contraception is completely free from side effects' (GOI, 1994: 29) as it went on to recommend 'newer hormonal methods which women can use for spacing'.[1] It is perhaps not coincidental that the World Bank in its influential Report *Investing in Health* had not only suggested that family planning services were to be part of a 'minimum essential clinical package' but that 'constraints on method availability include excessively restrictive screening requirements and unnecessary or duplicative approval procedures' (World Bank, 1993: 84). Indeed the World Bank's document on India's family welfare system also contained similar recommendations (Measham and Heaver, 1995). Given the availability of new-generation hormonal contraceptives, it is not surprising that health and women's groups, which had campaigned against these contraceptives, were profoundly disturbed.

This had, of course, been one of the non-negotiables in the demands put forward by the women's groups. This did not stem from a Luddite distrust of technology, nor from a post-modern distrust of the modernising state, nor indeed did it stem from perhaps legitimate fears that MNCs sought to exploit the cornucopia of a huge and growing contraceptive technology market with some help from policy planners. This arose from the experience of working with women in the country lacking access to the most minimal of health facilities, where the health care system had not even studied the morbidity—and indeed the mortality—imposed on women by much safer contraceptives, and where there was already evidence of misuse of such technologies. Indeed there is documentary evidence revealing women being denied truthful information about injectables in Dhanraj's well-known film *Something Like a War.* What is also to be remembered is that 'fascination with high technology contraceptives has continued to govern the Indian medical profession as well as Indian government officials. As a result, relatively simple methods such as the diaphragm have received very little attention, and the potential side effects of various contraceptive methods have been ignored. Indeed in their enthusiasm to introduce injectable contraception, providers even ignore the constraints on women's physical mobility, which may make it difficult for them to return for another injection within the stipulated time' (Desai, 1998: 59).

The third recommendation that caused a furor related to the use of army and paramilitary forces to promote the small family norm. Although the 'model' for this extraordinary suggestion of a 'pro-poor, pro-women' population policy was not spelt out, it was clearly Indonesia. In Indonesia, referred to by Bose, one of the members of the Expert Group, as a 'successful model' (Bose, 1994),[2] under a Population and Development Commission of the type envisaged under the Swaminathan Committee, a programme with widespread abuse of rights was created. Indeed the Chair of the Expert Committee, in the newspaper article referred to earlier, admitted that the paragraph containing this suggestion had been 'poorly worded' and legitimately 'evoked fears of coercion' (Swaminathan, 1994, cited in CWDS, 1997).

It might nevertheless be instructive to look at what one of architects of Indonesia's successful model had to say:

> Technology designed to increase contraceptive options, when used improperly, can also be abused. The experience of Indonesia with Norplant offers an instructive example. A Report by the National Family Planning Coordinating Board indicated ... only half the doctors involved in its use had received training in its use; most acceptors were unaware of side-effects; only one half had their medical history taken and some had no physical examination; recommended aseptic conditions were not maintained; those who wanted Norplant removed before five years had to pay for their removal; and some had their requests for removal refused.
>
> In addition, Norplant has been administered in part by means of 'safaris'—operations in which family planning personnel, accompanied by soldiers, enter a village, gather the populace together and expound upon the advantages of family planning, often with the implied threat that the village will be punished if family planning methods are not adopted. These safaris have historically played an important part in Indonesia's family planning programme, typically resulting in village women's mass acceptance of contraception—often of the one method being promoted at that particular moment by the government. (Boland et al., 1994: 99)

Zeidenstein, who headed the Indonesian Population Council for many years, presiding over these *safaris* indirectly, has expressed his *mea culpa*. But what of our experts who held this up as a model? Or those who continue to naïvely pretend that such contraceptives form a 'basket of choices' from which a 'stakeholder' makes an 'informed choice'. That the language of the market so pervades population discourse is nowhere more evident. There is the pretence that the industry manufactures value-neutral technologies, which enter the contraceptive technology market place, where a rational utility-maximising woman exercises her choice. However, we live in a situation where planning a small family is presented as an imperative, not a choice, and women are told that 'to choose otherwise is to fail as a human being and a citizen' (Chatterjee and Riley, 2001: 833). Who would recognise this for the real world where a poor, hungry, bedraggled woman going to the clinic for care is told she will have to have this injection, which is 'just like immunization'? (Dhanraj, 1993)

Interestingly, Srinivasan, one of the architects of family-planning policies in India in the past, and no critic of the Swaminathan Committee, notes that the 'recommendations have been influenced by major changes that are taking place in many countries of the world in an aftermath of the collapse of the Soviet Union ... and the increasing

role of the market and non-governmental forces' (Srinivasan, 1995: 60). Could this explain the role of the state? Could this explain too the anxiety about decentralisation—one of the current mantras of the World Bank—coupled with the centralisation implicit in the recommendation to establish the Population and Social Development Council (PSDC)?

The Expert Group received a slap in the face with the very public resignation of Dr Devaki Jain, one of its prominent members. In a strongly worded statement, she described the final version as 'shocking'. She pointed out that the Expert Group had 'unanimously agreed to abandon the entire current package of incentives and disincentives—including barring of entry into legislatures, and organized sector employment etc., on the basis of the size of the family. It was agreed that such policies were not only coercive but discriminatory against the poor, the Scheduled Castes, Scheduled Tribes and women, and wholly repugnant to the Directive Principles of the Constitution' (Devaki Jain, cited in CWDS, 1997: 42).

Further, Dr Jain pointed out that it had been agreed that basic needs, food security, livelihood, that is, a basic social and economic security floor for the poor was a necessary condition for enabling them to make reproductive choices. Dr Jain also pointed out that it had been agreed that high-technology contraceptives 'should not be introduced'. Describing these as the agreed pillars of the paradigm shift, the final document she said was a 'betrayal'. This betrayal thus converted 'the final document into a war on the poor, the Scheduled Castes, the Scheduled Tribes and women'. Dr Jain, therefore, refused to be a signatory to the Report of the Expert Group (ibid.).

Nonetheless the Draft Statement on the National Population Policy (NPP) (GOI, 1996) contained almost all these odious features. The Draft Statement called for a 'Panchsheel of gender relations', which would 'emancipate men from their mindset of greed, encourage women to rise to their full potential, achieve gender equity and eliminate gender conflicts' (ibid.: 6). Based on the understanding that 'if our population policy goes wrong, nothing else will have a chance to go right' (ibid.: 11), this Statement more or less echoed the Report of the Expert Group despite all the controversies it engendered. While it reiterated the dismantling of contraceptive targets and affirmed the governments commitment to quality health care, there were, at the same time, some interesting new directions. While incentives were to be discontinued in a time bound manner, what the

Statement mooted was 'community incentives aimed at encouraging the community to undertake activities resulting in reduction of birth rate, infant and maternal mortality rates' (GOI, 1996: 19). Was this an unconscious—or inded conscious—statement of the World Bank's 1995 recommendations? Given the experience of the Emergency and what this meant for the poorer sections of village communities, it is not surprising that this elicited disquiet in various circles. The Statement, noting that the family welfare programme has been under-funded, recommended that 'all States and Union Territories ... be encouraged to introduce user charges', although it added that 'care will be taken to ensure that pricing does not restrict access' (ibid.: 35). These user charges were envisaged not only as a source of funding but also for ensuring greater accountability from the services. Indeed, they were also seen as a source of funding for NGOs to make them 'self-sustaining' for the policy also announced a 'a new climate of partnership between the government and NGOs' (ibid.: 29).

Following the ICPD, and even before the government enunciated the Statement on the Population Policy, the government removed method-specific targets in April 1995 on an experimental basis in 17 districts across different states. The next year, at a meeting convened by the Ministry of Health and Family Welfare, the central government announced the abandonment of targets for the entire country, despite objections from several states (Visaria, 2002b). This was reported to have led to a fall in programme performance during the following years. Initially the post-1996 programme was described as a 'target-free approach' and in response to this concern with falling performance, it was rephrased the 'community need based approach'. But even during 1996–97, Andhra Pradesh is reported to have reintroduced targets, camps, and new incentives. Other states were soon to follow the example of Andhra Pradesh: while officially targets were removed, there continued to be an emphasis on target achievement in the assessment of workers as indeed the holding of camps.

In February 2000, the Government of India released the NPP document. The policy announced the 'commitment of the government towards voluntary and informed choice and consent of citizens while availing of reproductive health care services, and continuation of the target free approach in administering family planning services' (GOI, 2000: 2). The NPP also acknowledged a 'need to simultaneously address issues of child survival, maternal health and contraception, while increasing outreach and coverage of a comprehensive package of

RCH services by government, industry and voluntary NGO sectors working in partnership'.

The NPP listed its objectives in three time frames. The immediate objective of the NPP was to meet the unmet need for contraception and health infrastructure. The medium-term objective is to bring the total fertility rate to replacement levels by 2010 through inter-sectoral action, while the long-term objective is to achieve a stable population, consistent with sustainable development, by 2045.

Towards this end the goals set out include:

(*a*) making school education free and compulsory up to age 14;
(*b*) reducing IMR to below 30 per 1,000 live births;
(*c*) reducing the MMR to below 100 per 100,000 live births;
(*d*) promote delayed age at marriage;
(*e*) achieve 80 per cent institutional deliveries and 100 per cent deliveries by trained persons;
(*f*) universal access to information and counselling, and services for contraception with a wide basket of choices;
(*g*) 100 per cent registration of vital events—births, deaths, marriages, and pregnancy; and
(*h*) prevent and control communicable diseases, especially AIDS.

In pursuance of these objectives, the NPP lists 14 socio-demographic goals to be achieved at an all-India level by 2010. These include addressing the unmet need for basic RCH services, supplies and infrastructure, increasing access to schooling, reduction in IMR and MMR, universalisation of immunisation, delayed marriage for girls, universalising the number of deliveries by trained personnel and increasing the number of institutional deliveries, increased access to information and counselling, universal registration of vital events, control of communicable diseases, convergence of RCH programmes and Indian Systems of Medicine and Homeopathy (ISMH), and convergence of different social sector programmes.

The NPP stresses the need for decentralised planning, the empowerment of women for population stabilisation, child health and survival, collaboration with the voluntary and NGO sector, and encouragement of research in contraceptive technology. In order to promote the policy, it lists a number of measures. These include rewarding of panchayats and zilla parishads for 'exemplary performance' in family welfare and maternity benefits for mothers who give birth to their

first child after the age of 19. Also, a family welfare-linked social insurance is to be given to couples below the poverty line with two or less children who undergo sterilisation. The government proposes to reward couples who marry after the legal age at marriage, register their marriage, have their first child after the age of 21 years, accept the small family norm, and adopt a terminal method after the birth of their second child. It is also proposed to have a revolving fund for income generating activities by village-level self-help groups which will provide community health care services, crèches and child care centres in rural areas and in urban slums, a wide choice of contraceptives, facilities for safe and legal abortion, and vocational training for girls.

One of the central features of the policy is a commitment to a target-free approach and a refusal to use disincentives or coercion in order to achieve the demographic goals set by the state. The NPP also stresses the need for the involvement of local bodies at the lowest level, that is, the panchayati raj institutions (PRIs) in the achievement of the goals that make for population stabilisation. It suggests the devolution not only of rights, responsibilities, and powers to the PRIs but also of funds and powers of resource generation. In doing so, it is claimed that the NPP attempts to extend the scope of population policy to a broader notion of democracy and welfare.

The most striking aspect of the NPP is, of course, the fact that it was enunciated with no links to a health policy, which was then in the making. What is clear, however, is that despite recent Sex Ratio at Birth (SRB) data indicating a widespread fall in fertility in all states, including the north Indian states, evocatively christened BIMARU, the specified long-term objective of a stable population by 2045 is considered unfeasible (Visaria, 2002b). It bears recalling that in 1963, policymakers had proposed that the family-planning programme would lead to a decline in the birth rate to 25 by the mid-1970s, a level that is still to be achieved in large parts of the country. Further, all goals specified in the past for improvements in health, such as the lowering of IMRs have largely fallen by the wayside. The moot question that needs to be raised is whether a retreating state can, in fact, set the goals it has set out in the NPP.

Although the policy is said to have been inspired by the ICPD, it has been noted that not once does the NPP mention rights. Along with the incentives and disincentives which mark, in particular, the various state population policies, it has been argued that the population

policy is geared to achieve the 'democratization of disempowerment, resulting in the expansion of right-less people' (Baxi, 2002: 39).

Even before the NPP was announced, several state governments announced population policies of their own. In 1997, the Government of Andhra Pradesh announced its population policy (Government of Andhra Pradesh, 1997), followed by Rajasthan in 1999 (Government of Rajasthan, 1999), and Madhya Pradesh in early 2000 (Government of Madhya Pradesh, 2000). Shortly after the NPP was announced, Uttar Pradesh also announced its population policy (Government of Uttar Pradesh, 2000) while Maharashtra prepared a draft. Perhaps because many of these policies were drafted by a US consultancy firm active in the field of population around the world, there are overarching similarities among them. Although there are some common threads with the NPP, there are also some very significant departures. But we shall first briefly take a look at these state population policies.

The population policy of Uttar Pradesh links the growth of population to pressure on natural resources, and declares the inability of the state and its government to improve the quality of life of the people in the face of this growth in population. It highlights the need to address issues of gender and child development in an attempt to stabilise population growth.

The following are its specific objectives:

1. the need to reduce Total Fertility Rate (TFR) from 4.3 in 1997 to 2.6 by 2011–16;
2 proportionate increases in use of contraceptive methods by increasing demand for the same;
3. increase in average age of the mother at the time of the birth of her first child;
4. reduction in unmet need for both spacing and terminal methods;
5. reduction in MMR from 707 per 100,000 live births in 1997 to 394 by 2010 and to below 250 by 2016;
6. reduction in infant mortality from 85 per 1,000 live births in 1997 to 73 by 2010 and 67 by 2016;
7. reduction in incidence of STIs and RTIs; and
8. increase awareness of AIDS.

The strategies to be adopted to improve RCH include raising the average age at the time of marriage, introducing and focusing on adult

education, empowerment of women, and enhancing the involvement both of the private and voluntary NGO sector and the PRIs.

The policy lists a number of incentives and disincentives to achieve its objectives, which include some of the following:

(*a*) persons who marry before the legal age will not be eligibile for government jobs;

(*b*) 'performance-based' disbursement of 10 per cent of the total financial resources for PRIs. Panchayats which 'perform' well in the provision of RCH services will be rewarded. While the total transfer of funds will amount to only 4 per cent of the state revenue, the PRIs are to be entirely responsible for advocacy, identification of contraceptive needs, and recording of vital events; and

(*c*) the performance of medical officers and health workers is to be based on their performance in the RCH programme. While ostensibly, this would mean more 'efficient' RCH services, it would perhaps place extreme pressure on health workers to reach targets with regard to limiting of family size. Also, linking the performance appraisal of individuals to performance in providing RCH services would probably result in lop-sided health services provision, leading to an overemphasis on family planning and a neglect of other aspects of primary health care such as control of communicable diseases.

The document also calls for 'an active dialogue with the GOI for wider availability of injectables and other new technologies through private, commercial and government channels in the state' (Government of Uttar Pradesh, 2000: 86). The state thus intends to actively push the introduction of these newer technologies.

Finally, the policy has an explicit commitment to charging user fees ostensibly to improve the quality of services.

The population policy of Madhya Pradesh stresses the need to curb high fertility and mortality, which it argues impinge upon the quality of life and the balance between population, resources, and the environment. The policy document mentions the process of democratic decentralisation underway in the state and speaks of the need to change the thrust of family welfare from female sterilisation to include raising the age at marriage for women, provision of RCH services, universalisation of education, and empowerment of women.

The specific objectives of the population policy of Madhya Pradesh include:

(*a*) reducing total fertility rates from 4 in 1997 to 2.1 by 2011;
(*b*) increasing contraceptive usage and sterilisation services;
(*c*) increasing the age of the mother at the time of the birth of her first child from 16 years in 1997 to 20 years by 2011.
(*d*) reduction in MMR from 498 to 220 between 1997 and 2011 through greater registration of pregnant women, increases in proportions of institutional and trained deliveries, and pregnancy testing centres;
(*e*) reduction in IMR through increase in immunisation, use of oral rehydration solution (ORS) therapies for diahorrea in rural areas, reduction in incidence of acute respiratory infections (ARIs), coverage of pregnant women and children with Vitamin A, Iron, and Folic Acid (IFA) tablets;
(*f*) increases in levels of HIV testing;
(*g*) services for infertile couples; and
(*h*) universalising access to primary education by 2005 with a goal of ensuring that 30 per cent of girls in the age group of 14–15 years in 2005 would complete elementary education.

The strategies advocated by the policy document include the need to involve PRIs, and to empower women in the endeavour to achieve population stabilisation. A number of initiatives are suggested such as:

(*a*) making men realise their responsibility to empower women;
(*b*) strengthening local women's groups;
(*c*) reducing the burden of housework and drudgery on women by providing cooking gas connections and electricity to rural households; and
(*d*) reservation of 30 per cent of government jobs for women.

However, the population policy of Madhya Pradesh also has a number of disincentives. These include:

(*a*) persons who marry before the legal age are debarred from seeking government employment;
(*b*) persons who have more than two children will be debarred from contesting panchayat elections;

(*c*) the provision of rural development schemes in villages will depend upon the level of family-planning performance by panchayats. The flow of resources to PRIs is also to be linked to performance in the provision of RCH services. While there is no specific commitment to devolution of decision-making powers or resources to PRIs, these institutions are to be made responsible for the implementation of the RCH programme; and

(*d*) performance by panchayats in family planning is also to be linked to the starting of income generating schemes for women and poverty alleviation programmes.

The population policy of Rajasthan, like those of Madhya Pradesh and Uttar Pradesh, also links deceleration in the population growth rate to sustainable development. It mentions the need to reduce infant mortality, gender discrimination, and under-nutrition, and to increase household security.

The specific objectives listed include:

(*a*) the need to increase the median age at marriage for girls from 15 in 1993 to 19 by 2010 through education and increased awareness;

(*b*) increase institutional deliveries from 8 per cent in 1995 to 35 per cent by 2016 and assistance by trained persons in child delivery from 35 per cent in 1995 to 75 per cent in 2010;

(*c*) educate all women in the reproductive age groups about antenatal services establish linkages between female health workers, anganwadi workers, and trained dais at the village level; and

(*d*) Improved child health is to be achieved by assuring better quality ARI care, strengthening links between ICDS and health workers, and coverage of all children for immunisation and Vitamin A dosage.

With regard to operational strategies, the policy mentions the need to encourage men to use low-cost sterilisation services, and recognises the fact that the quality of the sterilisation and spacing methods need to be improved. While the thrust of the policy is on provision

of RCH services, importance is also given to the need to improve the management of service delivery systems, encourage involvement of PRIs, NGOs, the private sector, and cooperatives, and on the need for information, education and communication (IEC).

There are, however, a number of incentives and disincentives spelt out, which include the debarring of persons with two or more children from contesting elections. This norm is also applicable to other elected bodies like cooperative institutions and as a service condition for state government employees. The policy also states that 'the legal provisions barring people with more than two children from election to panchayats and municipal bodies is a testimony of the firm political will and commitment to population control' (Government of Rajasthan, 1999: 21).

The policy is cautious on the question of introducing new reproductive technologies, although the policy draft mentions that 'new contraceptive methods, as and when approved by the GOI will be introduced to make new technology accessible' (ibid.: 28). Finally, it mentions the need to address issues of infertility, RTIs, and female literacy.

The population policy of Maharashtra, which is yet to be finalised (Government of Maharashtra, 2000), begins with the need to bring down the rate of population growth. Its specific objectives include:

(*a*) reducing TFR to 2.1 by 2004;
(*b*) reducing CBR to 18 by 2004;
(*c*) reducing IMR to 25 by 2004; and
(*d*) reducing neonatal mortality to 2 by 2004.

The policy extract lists a number of measures in order to achieve these objectives. These include:

(*a*) the provision of subsidies and perquisites to government employees is to be linked to acceptance of the small family norm or permanent methods of family planning by couples;
(*b*) service in government jobs is also to be dependent on the acceptance of the small family norm;
(*c*) provision of village health schemes will also be linked to the performance of panchayats in the RCH programme;
(*d*) assessment of medical officers will depend upon their level of performance in the RCH programme;

(*e*) persons having two or more children will be debarred from contesting panchayat elections;
(*f*) other schemes include cash incentives to couples undergoing sterilisation after the birth of one or more daughters, training of dais, and strict enforcement of the Child Marriage Restraint Act, the ban on prenatal sex determination testing, etc. Also, women's self-help groups are to be set up at the village level; and
(*g*) funding of PRIs will depend upon performance in the RCH programme.

The policy makes no provision for the representation of women in elected or other bodies. It also does not mention the devolution of resources or decision-making powers to PRIs.

The Andhra Pradesh population policy links population stabilisation to improvements in the standards of living and quality of life of the people. It states that 'production of food may not keep pace with growing population ... pressure on land and other facilities will increase further, resulting in social tension and violence ... housing in both rural and urban areas will become a serious problem ... there will be an increase in unemployment ... . there will be serious pressure on the country's natural resources causing deforestation, desertification and more natural calamities' (Government of Andhra Pradesh, 1997: 4).

The demographic goals as stated in the policy include:

(*a*) reduction of natural growth rate from 1.44 in 1996 to 0.80 by 2010 and to 0.70 by 2020;
(*b*) reduction in CBR from 22.7 in 1996 to 15 by 2010 and to 13 by 2020;
(*c*) reduction in CDR from 8.3 in 1996 to 7 by 2010 and to 6 by 2020;
(*d*) reduction in IMR from 66 in1996 to 30 by 2010 and to 15 by 2020;
(*e*) reduction in MMR from 3.8 in 1996 to 1.2 by 2010 and to 0.5 by 2020;
(*f*) reduction in TFR from 2.7 in 1996 to 1.5 by 2020; and
(*g*) increase in couple protection rate (CPR) from 48.8 per cent in 1996 to 70 per cent by 2010 and to 75 per cent by 2020.

These objectives are to be attained by:

(*a*) the promotion of spacing, terminal, and male contraceptive methods;
(*b*) increasing the coverage of pregnant women for TT inoculation and provision of IFA tablets;
(*c*) increasing the number of trained and institutional deliveries;
(*d*) strengthening of referral systems and equity in accessibility of services;
(*e*) eradicating polio, measles, and neonatal tetanus by 1998;
(*f*) reducing diahorreal deaths, deaths due to ARIs, and incidence of low birth weight babies;
(*g*) increasing female literacy levels, increasing the median age at marriage for girls, and reduction in severe and moderate malnutrition among children; and
(*h*) reduction in the incidence of child labour.

The policy lists a number of operational strategies relating to the promotion of the terminal and spacing methods, ensuring safe deliveries as well as safe abortions, prevention and management of RTSs and STDs, increasing the average age at marriage of girls, and increasing female literacy and child survival. It also mentions a role for NGOs and the private sector in social marketing of contraceptives and delivery of health care.

The document explicitly lists a number of incentives to be used in the achievement of its objectives. These include the following:

(*a*) at the community level, performance in the provision of RCH services and the rate of couple protection will determine the construction of school buildings, public works, and funding for rural development programmes;
(*b*) performance in RCH services is also to be made the criterion for full coverage under programmes like Training of Rural Youth for Self-Employment (TRYSEM), Weaker Section Housing Scheme, and Low Cost Sanitation Scheme;
(*c*) funding for programmes under the Development of Women and Children in Rural Areas (DWCRA) and other social groups will be dependent on RCH performance.

(*d*) at the individual level, cash prizes will be awarded to couples adopting terminal methods of family planning;
(*e*) preference will be given to acceptors of terminal methods of contraception in the allotment of surplus agricultural land, housing sites, as well as benefits under Integrated Rural Development Programme (IRDP), SC Action Plan, BC Action Plan;
(*f*) special health insurance schemes for acceptors of terminal methods of family planning;
(*g*) educational concessions, subsidies, promotions as well as government jobs to be restricted to those who accept the small family norm.
(*h*) cash awards on the basis of performance to service providers; and
(*i*) an award of Rs 10,000 each to three couples to be selected from every district on the basis of a lucky dip, from the following categories: (*i*) three couples per district with two girl children adopting permanent methods of family planning; (*ii*) three couples per district with one child adopting permanent methods of family planning; and (*iii*) three couples per district with two or less children adopting vasectomy.

The policy document mentions the need for involvement of people's representatives, religious leaders, professional social bodies, professionals, chambers of industry and commerce, youth, women, and film actors and actresses. While it underscores the need for delegation of rights to PRIs, there are no provisions for devolution of resources to the panchayats.

What is striking is the similarities that run across these state population policies, with almost negligible variations, despite the vast differences in terms of epidemiological profiles and health infrastructure. This is perhaps to be explained by the fact that several of them were drafted with the assistance of a US-based private consultancy firm, the Futures Group. It might perhaps not be out of place to point out that the involvement of an agency such as this would have been unthinkable before India embarked upon liberalisation under the aegis of the World Bank. The Futures Group was funded by the USAID for its project named RAPID (Resources for Awareness of Population Impact on Development) which, 'with sophisticated computer technology dramatizes the perils of overpopulation with

simple graphs, highly selective statistics, and the kind of elementary Malthusian reasoning that attributes almost every social ill to high fertility' (Hartmann, 1995: 121). The Futures Group received $23 million for yet another project, named OPTIONS, which sought to provide governments in developing countries with advisors to draft population policies. It has been involved in assisting governments in drafting population policies in countries like Senegal and Nigeria where 'RAPID presentations have been a key to the acceptance of a national population policy' (Sai and Chester, 1990). Indeed the preparation of the population policy was a pre-condition for the grant of World Bank loans to both Senegal and Nigeria. The Futures Group was also involved in drafting the population policy of Egypt (Ali, 2003). In several cases, the data base of the Futures Group's projections have been seriously questioned while its predictions of population growth have proved to be way off the mark.

It is widely recognised, although reluctantly accepted, that health and population are governed by larger socio-economic issues, indeed determined by them. The Working Group on Population Policy (GOI, 1980) for instance recognised that population and development are two sides of the same coin; and that if levels of fertility are to decline, attention will have to be paid to increasing employment, income, food security, literacy, levels of health, and so on. The argument is that these in turn would induce declines in infant and child mortality even as they generate an increasing demand for family-planning services.

In contrast, the NPP is deafeningly silent on these larger issues contouring health and population. The question that, therefore, needs to be asked is what have the macroeconomic reforms of the 1990s meant for these critical determinants of health? How do these in turn impinge on issues in family planning? How have they affected structures of delivery of these services? Indeed the period has also seen health reforms with enormous consequences for health access among the poor.

While the evidence is often said to be ambiguous, there is a substantial body of evidence that suggests that reforms have meant a deceleration of employment in both rural and urban areas (Sen, 2002, see also Radhakrishna, 2002), a significant casualisation of the workforce, especially involving the female labour force (Unni, 2001), and a sharpening of income inequalities with a contraction of incomes in the lower deciles of the population (Dev, 2001: 47). Thus the *Economic Survey, 2001–2002* (GOI, 2002) notes that in the

period 1978–83, the rate of growth of population was 2.19 per cent per annum while the rate of growth of employment kept closely at 2.17 per cent per annum. Between 1983 and 1988, the rate of growth of population came down to 2.14 per cent per annum, while the rate of growth of employment declined to 1.54 per cent. Between 1988 and 1993, while the rate of growth of population maintained a decline, to 2.10 per cent per annum, employment generation increased to 2.43 per cent per annum. Between 1993 and 2000, while the rate of growth of population came down further to 1.93 per cent per annum, employment generation declined to the abysmal level of 0.98 per cent per annum. While public sector employment grew at 1.52 per cent per annum between 1983 and 1994, it showed a negative growth of –0.03 per cent between 1994 and 2000. Between 1991 and 2000, the growth rate in the organised private sector declined from 1.24 per cent per annum to 0.97 per cent per annum. The *Economic Survey* also notes a declining trend in the importance of self-employed category in both rural and urban areas and an overall increase in the casualisation of the women workforce from 31.4 per cent in 1972–73 to 40.9 per cent in 1997 (GOI, 2002: 246).

The annual rate of growth of employment in rural areas fell to 0.86 per cent over the period from 1993–94 to 1999–2000. This is not only less than one-third of the rate of growth in the previous period from 1987–88 to 1993–94, it is less than half the projected rate of growth of the labour force in the same period. Indeed this has been the lowest rate of growth of rural employment in post-Independence India. A study by the National Council of Applied Economic Research (NCAER) concluded that feminisation of wage labour, indicative of a bias against women, is a reality across a large number of states (Shariff, 1999). Even in the so-called developed states, the employment opportunities available to women are primarily in manual waged labour. That is to say, given the lack of employment in the rural non-agricultural sector, women are increasingly being pushed back into agriculture. Indeed, this study also notes an increasing participation of female children in wage labour. What is even more striking is that during the reforms period, the growth of agricultural production virtually came to a halt, and has been negative during the last few years. The agrarian crisis is testified too by the epidemic of suicides by farmers all over the country.

Yet, as compared to a buffer stock norm of 17 million tonnes of food-grain, India sits on a shameful and growing stock of 63 million

tonnes. This is not entirely surprising since this attests to the 'success' of the neo-liberal policies in income deflation in the population at large. That is to say, given the squeeze of real incomes, it is in a sense natural to have unsold food-grains. Post-reform fiscal policies have also ensured a doubling of the price of food-grain for above poverty line households, while for the below poverty line (BPL) households the price increase has been of the order of 80 per cent. This is a double tragedy for not only are people starving as food goes waste in public godowns, but the government is also wasting—as a matter of policy—an opportunity to do something about the low employment opportunities that prevail. Indeed, at the same time, the government instead of bolstering food-for-work programmes and utilising the food reserves to do so, has cut down on them.

The *Economic Survey 2001–2002* admits that increases in procurement prices have meant that market prices have at times been lower than the rates being offered by the public distribution system (PDS), leading to a low off-take. For the BPL category, there has been a 61.4 per cent increase in the issue price of wheat and rice. At the same time, an estimated 350 million people are unable to meet their minimal calorie requirements. The National Family Health Survey (NFHS) reveals that more than a third (36 per cent) of women in India had a Body Mass Index (BMI) below 18.5, indicating an extraordinarily high prevalence of hunger, and 52 per cent of women were anaemic. Almost half the children under 3 years of age (47 per cent) were underweight and a similar percentage (46 per cent) were stunted. The proportion of children severely under-nourished was 18 per cent according to weight for age and 23 per cent according to height for age. Wasting affected 16 per cent of children in this age group (International Institute for Population Sciences [IIPS], 2000).

Is it any wonder then, that as the Table 5.1 makes evident, IMRs, accepted as one of the most crucial determinants of family planning, have been stagnating during the 1990s? Between 1981 and 1990, the all-India IMR declined from 110 per 1,000 live births, to 80; between 1990 and 1999 the IMR declined from 80 per 1,000 live births to merely 70. The annual rate of decline thus decelerated from 2.72 per cent in 1981–91 to 1.56 per cent in 1991–99. What is even more worrying is that this overall decline is accompanied by an increase in IMR in several states in the country. It is not surprising, therefore, to find that India's position in the international ranking of human development has slipped from 124th to 127th.

Table 5.1 All-India Infant Mortality Rates

Year	*All India*	*Rural*	*Urban*
1981	110	119	62
1982	105	114	65
1983	105	114	66
1984	104	113	66
1985	97	107	59
1986	97	105	62
1987	95	104	61
1988	95	102	62
1989	91	98	58
1990	80	86	50
1991*	80	87	53
1992*	79	85	53
1993*	74	82	45
1994*	74	80	52
1995*	74	80	48
1996*	72	77	46
1997*	71	77	45
1998(ii)	72	77	45
1999(iii)	70	75	44

Sources: Office of the Registrar General of India (1999), *Compendium of India's Fertility and Mortality Indicators, Sample Registration System (SRS)*, GOI, New Delhi; Office of the Registrar General of India (2000), *Selected Socio-Economic Statistics: India 1999*, GOI, New Delhi; ORGI, Sample Registration System (2001), *SRS Bulletin*, 35:1.

Note: *Excludes Jammu and Kashmir.

A significant feature of liberalisation has been the dismantling of social welfare activities of the state, inadequate as they were. Thus while the PDS was being whittled down, India's commitment to universal and comprehensive primary health care, as a signatory to the Alma Ata Declaration and as enunciated in the National Health Policy of 1983, has been significantly weakened. As a result, universal and comprehensive primary health care finds no mention at all in the NPP. Indeed that we had the announcement of a NPP without links to a National Health Policy, is abundant evidence of distorted priorities.

As the data in Table 5.2 make evident, health expenditure has shown a secular decline, particularly marked in the programmes for the control of communicable diseases, while that for family planning has shown a continuing increase. At the same time, the state has provided

Table 5.2 Expenditure on Health and Family Welfare (in rupees crore)

Plan	*Period*	*Amount*	*Total Plan Investment (All Development Health)*	*Health (Centre and States)*		*Family Welfare*		*Control of Communicable Diseases*	
				Outlay/ Expenditure	*% of Total Plan*	*Outlay/ Expenditure*	*% of Total Plan*	*Outlay/ Expenditure*	*% of Total Health*
First	1951–56	Actuals	1,960	65.2	3.33	0.1	0.01	23.1	16.5
Second	1956–61	Actuals	4,672	140.8	3.01	5	0.11	64	28.4
Third	1961–66	Actuals	8,576.5	225.9	2.63	24.9	0.29	69	27.7
Annual	1966–69	Actuals	6,625.4	140.2	2.12	70.4	1.06	23.1	10.2
Fourth	1969–74	Actuals	15,778.8	335.5	2.13	278	1.76	127	11.1
Fifth	1974–79	Actuals	39,426.2	760.8	1.93	491.8	1.25	268.12	11.5
(79–80)		Actuals	12,176.5	223.1	1.83	118.5	0.97		
Sixth	1980–85	Outlay	97,500	1821	1.87	1010	1.04	524	27
Sixth	1980–85	Actuals	109,291.7	2052.2	1.85	1387	1.27		
Seventh	1985–90	Outlay	180,000	3392.9	1.88	3256.3	1.81	1012.7	7.7
Seventh	1985–90		218,729	3688.6	1.69	3120.8	1.43		
(90–91)		Actuals	61,518	960.9	1.56	784.9	1.28		
(91–92)		Actuals	65,855	1042.2	1.58	856.6	1.3		
Eighth	1992–97	Outlay	434,100	7582.2	1.75	6500	1.5	1045	4.2
Ninth	1997–2002	Outlay	859,200	5118.1	0.6	15120			

Source: Government of India (Planning Commission) (1997), *Ninth Five Year Plan, 1997–2002, Vol. II*, GOI, New Delhi.

impetus to the growth of the private sector in health care through a range of subsidies and schemes. It is thus not surprising that even as health care becomes more inaccessible, and expenditure on health care is emerging as the leading cause of indebtedness (Krishnan, 1999), reports of starvation deaths and outbreaks of epidemics have started pouring in (Baru and Sadhana, 2000).

The collapse of the public health system, without which, of course, even the NPP cannot be implemented, has been hastened by macroeconomic policies initiated by the government. This has not only led to cuts in public health expenditure, marked in real terms, but by introducing cuts in expenditure in other crucial sectors of the economy, undermined the grounds for health in the population.

It is either taken as self-evident, or argued, that cuts in the social sector are necessary since we do not have funds for additional expenditure. This is, of course, a fallacious argument, veiling a political decision not to do so. One reason why the government has introduced expenditure cuts has been because the government is unwilling, or progressively less able, to collect taxes, even at levels that existed before the reforms period. Thus the tax to GDP ratio has declined from more than 13 per cent in 1990–91 to 9 per cent in 2000–2001. At the same time, of course, this implies that regressive indirect taxes as a proportion of revenue has increased—taxes paid for largely by the poor. But just the reduction in direct taxes represents uncollected revenues of 4 per cent of the GDP, which is almost three times the entire expenditure on public health, medicine, and family welfare by the central and state governments combined. On another tack, as India goes in for nuclear weapons, it has been estimated that the cost of one nuclear warhead would amount to more than the annual cost of primary health centres in every rural and urban settlement in the country.

It is frequently argued that the health of women in the country is appalling, as indeed it is. It is further argued that providing family-planning services to women would lead to declines in unwanted births and thus in maternal mortality, which is unconscionably high. These arguments, partially true, were familiarly used earlier as the justification for the maternal and child health programme. In the 1990s, the argument that women suffer huge—and unquantified—reproductive morbidities, even as the spectre of AIDS loomed large, was, as we saw earlier, used to justify the new RCH approach.

But to recall, there are, however, significant problems with this approach that assumes that reproductive causes alone largely account

for the mortality load borne by women. Data on deaths among females in the country reveals that deaths due to reproduction, high as this is, account for merely 2.4 per cent of all causes of deaths. Within the reproductive age group of women, they account for about 12 per cent of deaths. The focus of the RCH approach in the NPP is thus epidemiologically misplaced (Qadeer, 1998). In all age groups among women, including the reproductive age groups, communicable diseases and anaemia, account for a significantly higher proportion of deaths. Indeed deaths among women with anaemia, who are not pregnant are twice the number of deaths among women who are. In other words, given the prevailing distribution, causes and load of deaths, a RCH approach addresses merely the tip of the iceberg. This pattern of diseases and deaths, dominated by the quintessential diseases of poverty and hunger, can only be dealt with by a comprehensive system of universal primary health care. Even this limited RCH package of services, epidemiologically blinkered, can only be delivered by a public health system considerably strengthened.

Significantly, the fourth report of the committee on the empowerment of women, looking into the health and family welfare programmes, has for the first time, recognised the significantly high morbidity among women from causes other than reproductive ones. It points out, for instance, that tuberculosis takes a huge toll on young women's lives and indeed that malaria kills more women than maternal mortality (cited in *EPW*, 2002: 2515). But then the focus on RCH consistently misses the woods for the trees.

Indeed, noting that vertical programmes had not been successful, and that a vertical family-planning programme had considerably weakened health care, the Expert Group had boldly proposed the integration of programmes in order to strengthen health care. While this has not been heeded, the NPP has accepted the need to 'incorporate advances in contraceptive technology and, in particular the newly emerging techniques into programme development' (NPP, 2000: 27). What this refers to, of course, is injectable contraceptives and implants. Indeed, earlier in 2003, the Ministry of Health and Family Welfare announced plans to initiate trials with the injectable contraceptive Net En in 12 medical colleges around the country (Rao, 2001a).

While Net En has been available in the private sector since 1994, its use was restricted since it was felt that the use of such a contraceptive required medical care and follow-up not readily available in

the country at large. In a large trial carried out by the ICMR in the 1980s, close to 45 per cent of users had discontinued the method by the end of two years citing complications. Indeed the ICMR trial revealed not just a high drop out rate but also that a significant proportion of users had failed to regain fertility on cessation of use, making the method unsuitable as a temporary contraceptive (Bal et al., 2000). Moreover, a high rate of failure had been reported within the first six months of use, raising the vexed question of the risk to the foetus *in utero*.

One very real fear is that given coercive population control policies, the vast potential for misuse of this contraceptive will become a reality. With a target-driven population control policy, despite the NPP's commitment to the contrary, the needs of a woman user are overlooked in the haste to bring down birth rates. Indeed, it was this very feature at a camp in Andhra Pradesh in 1985 that led women's groups to file a petition in the Supreme Court against injectables (ibid.).

While the NPP is unequivocal in rejecting any form of coercion, the incentives to be given to couples and to panchayats for generating acceptance of family planning sits uneasily with this commitment. Yet it is the population policies announced by various states that blatantly violate the letter and spirit of this commitment of the NPP. These state policies, with a slew of disincentives, have brought in coercion. Thus the policies of Uttar Pradesh, Madhya Pradesh, Rajasthan, and Maharashtra disqualify persons married before the legal age at marriage from government jobs, link financial assistance to panchayats to family-planning performance, and in a move recalling the period of the Emergency, link the assessment of medical officers and other health personnel to performance in the RCH programme. The population policy of Madhya Pradesh links the provision of rural development schemes, income generating schemes for women, and indeed poverty alleviation programmes as a whole, to performance in family planning. Both Rajasthan and Maharashtra make 'adherence to a two-child norm' a service condition for state government employees. Maharashtra in a government order, since rescinded in the face of protest, announced the two-child norm as an eligibility criterion for coverage under a range of schemes for the poor, including access to the PDS and education in government schools. Andhra Pradesh, which has many of these features in its policy, goes further and links construction of schools, other public works, and funding for other rural development

schemes to performance in family planning. Allotment of surplus agricultural land, housing schemes, benefits under the IRDP, the SC Action Plan, and the BC Action Plan are also linked to acceptance of sterilisation. In a macabre metaphor of the lottery that is the life of the poor in the country, awards of Rs 10,000 are to be given to three couples per district, chosen by lottery, who have been sterilised after the birth of two children.

These policies are in complete disjunction with the NPP and indeed with the commitments made by the Government of India at the 1994 ICPD in Cairo. It is curious that policymakers, so anxious to control numbers, need to be reminded that such policies are completely unnecessary as a significant demographic transition is underway in large parts of the country. And indeed that areas where this transition has lagged behind need assistance towards strengthening their health services and augmenting their anti-poverty programmes and not measures that punish the poor. As the NPP itself points out, there is a large and unmet need for family planning services. The NFHS found that contraceptive prevalence had increased from 41 per cent in 1992–93 to about 48 per cent in 1998–99, with female sterilisation being, of course, the mainstay of the programme. If the women who say they want to space or limit their births were to obtain access to safe contraception, the contraceptive prevalence rate would increase from 48 to 64 per cent. Unmet need for contraception is highest—about 27 per cent—among women below the age of 20 years; this need is entirely for reversible and spacing methods. Unmet need is also high among women in the 20–24 years age group, with about 75 per cent of this group needing spacing methods (IIPS, 2000). This is, of course, not to argue that women with an unmet need for contraceptives, do not have other needs over which contraception should be privileged. Nevertheless, in such a situation, without meeting this unmet need, to propose punitive measures is both irrational, absurd, and morally indefensible.

The disincentives proposed are anti-poor, anti-Dalit, and anti-adivasis with these weaker sections having to bear the brunt of the withdrawal of a range of measures meant precisely to mitigate poverty and deprivation. Almost 60 per cent of Dalits are wage labourers with extremely high levels of unemployment and underemployment. Macroeconomic policies, including in particular low levels of public investments, as was the case during the reform period, has a direct bearing on issues of employment and wages. Privatisation

and NGO-isation will thus curtail access to all kinds of services for this large section of the population. The NFHS for 1998–99 reveals that the TFR, reflecting socio-economic deprivation, is 3.15 for Scheduled Castes (SCs), 3.06 for Scheduled Tribes (STs), 2.66 among Other Backward Classes (OBCs), and 3.47 among illiterate women as a whole (IIPS, 2000). In contrast, it is 1.99 among better-off women educated beyond Class 10. Imposition of the two-child norm and the disincentives proposed in the state policies would thus mean that significant sections among these already deprived populations will bear the brunt of the state's withdrawal of ameliorative measures, as pitiably inadequate as they are. In addition to privatisation that *de facto* deprives SCs and STs of jobs in the organised sector, these explicit policy measures will further curtail employment opportunities available to them in the public sector.

The Dalits, the adivasis and the OBCs also bear a significantly higher proportion of the mortality load in the country. The NFHS reveals that the IMR among the SCs, STs, and OBCs was 83, 84, and 76 respectively compared to 62 among others. Similarly the under five mortality rate is 113 among the SCs, 126 among the STs, and 103 among the OBCs compared to 82 among others. While it is true that all these categories of the population are not homogenous, it is nevertheless striking that there are such significant differences in infant and child survival among them. Clearly then, to impose a two-child norm under such circumstances is immoral. Coming to the health status of women, the NFHS reveals that 65 per cent of women among the STs and 56 per cent of women among the SCs suffered from anemia, compared to 47.6 per cent among others. In the case of antenatal care, about 61 per cent of ST and SC mothers received antenatal check-up as against 80 per cent for others. About 72 per cent of the births among SC women and 81 per cent of births among the STs took place at home, compared to 59 per cent among others. Conversely, only 21 per cent of births among SCs and 18 per cent among STs women took place in a medical institution. Of the total home deliveries among SC and ST women, more than 40 per cent were attended to by the TBA or a *dai*. Only 36 per cent of women among SCs and 23 of women among STs received the attention of a public health personnel. Instead of dealing with these differentials and their causes, what the population policies seek to do is to punish victims of deprivation.

The disincentives proposed are also anti-women since women in India seldom decide the number of children they wish to bear, when to bear them, and indeed have no control over how many of them will survive. Debarring such women from contesting elections to panchayats makes a mockery of policies to empower women. They will further provide an impetus to some women to resort to sex-selective abortions, worsening an already terrible sex ratio in the country. They are also anti-minorities since the marginally higher TFR among some sections of these communities are a reflection of their poorer socio-economic situation. It need hardly be added that just as the Hindu rate of economic growth is a chimera, so is a Muslim rate of population growth. Indeed the draft policy of Gujarat, that crucible of genocidal Hindutva politics, besides carrying a range of disincentives, also explicitly makes a two-child norm mandatory for all communities (Khanna, 2001).

It has been reported that a study commissioned by the Ministry of Health and Family Welfare did indeed find expectedly dolorous outcomes with the imposition of the two-child norm for panchayats (*The Hindu*, 2 July 2003, p. 5). The study, covering Andra Pradesh, Haryana, Madhya Pradesh, Orissa, and Rajasthan concluded diplomatically: 'The way the norm is conceptualized and currently implemented is not without serious unintended negative consequences' (ibid.). Thus 75 per cent of those disqualified from contesting elections to the PRIs were from the SC, ST, and OBCs communities. In Orissa and Andhra Pradesh, 55 and 48 per cent respectively of those disqualified were women. The study also found an increase in the number of pre-natal sex determination tests, followed by sex selective abortion. It also found an increasing incidence of desertion, divorce, and the 'donation' of children in adoption. Yet another study concluded that 'women, especially from marginalized groups suffered the consequences of the Act from causes beyond their control' (Sama, 2003: 2).

Finally, the state policies further violate several fundamental rights (the right to privacy, the right to life, the right to livelihood, amongst others), the Directive Principles of the Constitution of India, as well as several international Covenants that India is signatory to, including the ICRC, CEDAW as well as the Beijing Platform of Action, and the Cairo Declaration.

One deeply disturbing feature of the current scenario, that population policies of this nature worsen, is the masculinisation of sex

ratios at birth and of juvenile sex ratios. Over the twentieth century, the decline of the sex ratio in the country has been secular and fairly monotonous. The 2001 Census, however, indicated a happy improvement in the overall survival of females as the sex ratio increased from 927 to 933. Nevertheless this was accompanied by a decline in the sex ratio in the 0–6 years from 945 to 927 between 1991 and 2001. The decline was steeper in the classical region of the north and west referred to by Oldenberg as the Bermuda triangle for missing females (Oldenberg, 1992). What is more alarming is that this decline in child sex ratio (CSR) is spreading beyond this region and to communities hitherto considered immune. Indeed the masculinisation of CSR has been particularly precipitate among the SC population (Agnihotri, 2000). Accompanying this has been a marked masculinisation of the SRB. A norm of 105 male births to 100 female births was arrived at in 1958. SRS based estimates of the SRB in 1998 shows an all-India figure of 111 males per 100 females, indicative of female sex selective abortions (Premi, 2001).

A large number of explanations have been proffered for the devaluation of female lives in India. These range from marriage and kinship patterns, to female work participation rates in wheat and rice cultivation, to laws governing inheritance of property and so on. Evidence of this was evident as early as the 1961 Census as revealed by Krishnaji, which showed a significant relationship between landholding and negative sex ratios (Krishnaji, 2000). Harris-White (1996), Heyer (1997), and Clark (1987) have all drawn attention to the imbrication of Brahminical marriage patterns among other castes, the interlocking of class and social mobility and the spread of dowry. I would suggest that along with the spread of Hindutva ideologies, state policies are also actively contributing to the reinforcement of traditional anti-female ideologies and in engendering masculinity.

Even when the problem is recognised, the ways in which this has been dealt with, has been appalling. The Indian Medical Association, the UNICEF, and the National Commission of Women organised a meeting with so-called religious heads, the very struts of patriarchy, defenders of widow immolation. Indeed, Madhu Kishwar defended this as 'cost–effective' (Rao, 2001a).[3] The meeting with religious heads was reportedly taken over by Sadhvi Rithambara, to the embarrassment of many naïve participants. No amount of cost-effectiveness justifies marching along these self-appointed religious leaders, who

are the struts of patriarchy and indeed worse, of appalling murderous evil, in our country. We cannot sup with the Devil, especially when he quotes the scriptures.

What is often not recognised is the withdrawal of the state—from health, education, employment generation, and actively combating anti-women traditional values—engenders both the feminisation of poverty and the shrouding and enfoldment of women, sacrificing them to the altar of the family. Punitive and coercive population policies, especially those announced by several states, are an invitation to female sex-selective abortion. Not curiously, a large number of respondents in a study of female infanticide in Salem district explicitly stated this. The women interviewed felt that they could not accept sterilisation as it interfered with their ability to work on the fields. What they were doing, they argued, was 'traditional' and achieved precisely what the Government of India wanted. A study in Mumbai revealed that a majority of doctors performing sex-selective abortions stated that they did so in order to control population growth (FRCH Study, cited in Agnihotri Gupta, 2000). The clients were largely educated and came mainly from the middle classes.[4]

The appeal of the reified concept of rights was also evident during the hearing of the Parliamentary Committee on the Empowerment of Women on the issue of Pre-Natal Diagnostic Techniques (PNDT) (Regulation and Prevention of Misuse) Amendment Bill 2002, that considered representations from the public to proposed modifications in the PNDT Act. The modifications, in essence, sought to include a range of pre-implantation diagnostic techniques in the purview of the Act, making their use for sex selection actionable. They also sought to create structures for the registration and monitoring of all facilities offering these services, as well as tightening punitive measures for the violation of the Act. Not surprisingly, representatives of the medical industry—that has contributed to the dismal scenario of the adverse sex ratios in the country—objected to the proposals on the grounds that such technologies were essential for bringing down unconscionable levels of maternal mortality and for reducing the incidence of congenital abnormalities.

While it is indeed true that the MMR in the country is high and needs to be reduced, it is nevertheless true that the contribution such technologies can make towards this is extremely limited, if not non-existent. To repeat, as epidemiological data on maternal deaths

in the country indicate that even within the reproductive age group of 15–45 years, causes related to reproduction account for merely 12 per cent of all causes of death. Even within the reproductive age group of women, anaemia and communicable diseases take a far higher toll. Excluding these major causes of death, the most significant factor is lack of access to safe and effective natal care. In the absence of these, to argue that pre-natal diagnostic technologies are necessary to bring down the MMR is clearly spurious.

Representatives of health groups and women's groups pointed out that the medical profession's commitment to bringing down congenital abnormalities is highly selective and thus deeply suspicious (Delhi Science Forum, 2002). Some years back, when health groups and women's groups, were involved in a campaign against high dose oestrogen–progesterone based contraceptives, since banned, on the grounds that they induced congenital abnormalities in foetuses exposed *in utero*, the medical profession completely disregarded the existing scientific information and campaigned against the ban.

It was also pointed out that scientific evidence on the prevalence of congenital abnormalities in India is woefully inadequate. There is also no data to substantiate the claim that ultra-sound and such other technologies that have been so cavalierly used have indeed brought down the prevalence of congenital abnormalities. It is thus incumbent on those who wish to continue to use such technologies on this ground to furnish data in support of their claim. On the other hand, those who wish to curtail the misuse of these technologies, have data on increasing masculinisation of both the CSR (0–6) and the SRB, attesting to sex-selective abortions on a large enough scale not warranted by the prevalence rates of congenital abnormalities.

From a public health perspective, then, there is very little role for such technologies. Doctors can perhaps be forgiven for not reflecting on Say's Law that supply creates its own demand. They have evaded the responsibility of creating an injection culture in our population just as they now evade the responsibility of a 'tests' culture. But they cannot be forgiven for not knowing that the prevalence of congenital abnormalities occur in 1.5 per cent of all pregnancies and of these, possibly 50 per cent can be identified by non-invasive technologies. Yet there has occurred an epidemic of the spread of sonogram and ultra-sound clinics in a completely unregulated manner. Indeed Pre-Implantation Diagnostic Techniques (PDTs) are already available in our metropolitan cities.

What this underscores is not epidemiological priorities or indeed concerns about women's health but the power of the global reproductive technology industry to seek markets. There is no doubt that India constitutes a large and lucrative market with some unscrupulous and other misguided doctors' connivance.

What this calls attention to, above all, is the urgent need to monitor and regulate all public health technologies and practices, especially given the fact that India has the dubious distinction of being one of the largest and unregulated private health care markets in the world. This is the case with pre-natal and natal diagnostic tests as with contraceptive technologies.

Representations to the Committee pointed out that the limitations of legal action alone to curb female sex selective abortions are very real. Yet, they are nevertheless crucial in a society to establish norms of ethical medical practice.

In a sense rising to the defense of the medical industry, Madhu Kishwar, a leading anti-feminist pleaded against widening of the ambit of the law. Kishwar argued that women in India exhibited choice, indeed agency when they undertook sex-selective abortions. It is not, she said, for the state to intervene in the family, which constitutes the deeply personal. On the other hand, Kishwar also argued that a corrupt state merely brought in laws in order to increase levels of corruption. What, of course, was forgotten is that far from showing their agency, women who took recourse to sex-selective abortions were doing so under pressure from families and were thus victims of patriarchy (Bhalla, 2004). What this also reveals is the miraculous power of the concept of reified rights to turn things on their head, and indeed become part of the arsenal to further oppress and subordinate women.

That the law is a double-edged weapon is, of course, a truism. On the one hand, it is true that activists wishing to change things have a tendency to take recourse to the law. This has been occasionally successful as in the case of quinacrine sterilisations, when in response to a public interest petition filed by the All-India Democratic Women's Association and the Centre of Social Medicine and Community Health, Jawaharlal Nehru University, the Supreme Court stepped in to issue a ban (Rao, 1998). On the other hand, when the Rajasthan's population policy, disqualifying elected representatives of panchayats with more than two children was challenged, the Rajasthan High Court endorsed the state's position on the constitutional validity of the

law, which is, of course, debatable. The judges' reasoning is revealing: 'These provisions have been enacted by the legislature to *control the menace of population explosion* .... The government is spending large sums of money propagating family planning. One of the agencies to which the project of family planning has been entrusted for implementation is the gram panchayat. The *panches* and *sarpanches* are to set the example and maintain the norm of two children. Otherwise what examples can they set before the public' (Sarkar and Ramanathan, 2002: 42).

A number of health groups and women's groups in the country have repeatedly protested these draconian features of state population policies, indeed even compelling states like Maharashtra and Gujarat to reconsider theirs. Demonstrations have been held in various states, memoranda submitted, and appeals made to the highest authorities in the country. Among other reasons cited, these memoranda have pointed out the fact that in the states where they have been imposed, as in Haryana, Madhya Pradesh, and Rajasthan, women have been deserted or forced to undergo sex-selective abortions. In general, such a norm provides an impetus for an increase in sex-selective abortions, worsening an already terrible child sex ratio in the country.

As the NPP itself acknowledges, there is a large need for health and safe contraceptive services. To propose punitive measures in this context is clearly absurd. In spite of this concerted campaign, the State Law Commission of Uttar Pradesh has drafted the Uttar Pradesh Population Control Bill, 2002 (Government of Uttar Pradesh, 2002). This Bill codifies all the anti-human rights features of the state population policies, with a slew of disincentives for 'any person who shall be deemed to have committed a breach of the family planning norm if he has more than two living children, one of whom is born on or after the appointed date' (Government of Uttar Pradesh, 2002: 1). These include disqualification from employment and promotion, disqualification from membership in any cooperative union, housing society, public corporation, and so on, denial of bonus honorarium or any other benefit, denial of increments, denial of housing loans, etc. Failure to inform the authorities of the birth of a child in violation of the norm would invite disciplinary action, including dismissal from employment.

At the same time, sinister moves are afoot at the centre to undo the very positive features of the NPP. Press reports,[5] indicate that a

'Strategy Paper' has been prepared to review the NPP. This anonymous document, leaked to the press, does not carry the imprimatur of either the National Population Commission or the Ministry of Health and Family Welfare and thus lacks the mandate of any statutory advisory or decision-making body. It was, however, distributed by the National Planning Commission and was freely available. The only conclusion that could be drawn is that influential people within the government, disillusioned with or un-converted by the Cairo rhetoric, were, in a sense, testing the waters before bringing in more coercive population policies.

The document itself is poorly substantiated by data, deeply contradictory, and shockingly at variance with the NPP, 2000. The NPP, as we noted earlier, recognises that there is a large and unmet need for quality health and reproductive and child health services; it also recognises that IMRs are still unconscionably high and that there is an urgent need to strengthen health services, attending particularly to the needs of the poor and the marginalised. Above all, it recognises the need for quality services which respect the dignity of people, even as it emphasises equity.

The 'Strategy Paper', on the other hand, is drafted in the ahistorical and unscientific language of Malthusian scare-mongering. While it recognises that infrastructure is weak, and that the quality and coverage of health services are poor, it absurdly attributes these failures of the state primarily to population growth. While it recognises that there is an adverse sex ratio, it is not averse to calling for a two-child national norm when it is absolutely clear that such norms have indeed contributed to the adverse sex ratio. While it recognises that there is an unmet need for health and family welfare services, it contradictorily calls for a range of incentives and disincentives, holding up Andhra Pradesh as an example. Further, it argues, incorrectly, that China continues to have a one-child norm. In any case, comparisons between India and China are inapposite for a large number of reasons, including per capita incomes, achievements in health, equity, and education that India can unfortunately not boast of. Finally, the so-called strategy paper invidiously suggests that concern for rights and equity are current only in NGOs financially supported by the UNFPA. As the *Economic and Political Weekly* noted in an editorial, does this influential paper imply that the commitments made at Cairo were 'a sham'? The editorial also notes that the 'reasons being offered for this change of approach are specious' (*EPW*, 2002: 2515).

It has been noted that 'there is hardly any worthwhile reason to believe that disincentives that are indirectly coercive are likely to have any significant effect on demographic trends' (*EPW*, 2000: 3363).

Health groups and women's groups in the country had, even before the ICPD, and indeed with no links to the UNFPA, critiqued the family-planning policy as it then existed. The population policy in the country, it was noted, 'has been one of fertility control, pursued relentlessly, and at times coercively, bringing disrepute to the family planning programme and compromising women's health and accelerating the declining sex ratio' (CWDS, 1997: 20). It is possibly in the light of such critiques, along with the commitments made at the ICPD at Cairo, that the NPP 2000 abjures targets, incentives, disincentives, and specifying a two-child norm.

What the so-called strategy paper does not seemingly wish to recognise is that given the age structure of the population, population growth will continue despite fall in the birth rate due to what demographers call momentum, that is, the effect of a young age structure caused by high population growth rates in the recent past. With a large proportion of the population—almost 60 per cent—below the age of 30 years, further growth of the population is inevitable, unless, of course, mortality increases, which cannot be the aim of policy. Population momentum contributes to as much as 69.7 per cent of current population growth. A further 24.4 per cent is due to the unmet need for family planning services (Sen and Iyer, 2002). In view of these facts, that the strategy paper can conceive of punitive disincentives is indicative of nothing short of a eugenic mindset.

It is in this context that a large number of health groups and women's groups came together to present a memorandum to the National Human Rights Commission (Rao, 2002). The memorandum made the following three pleas to the NHRC:

(*a*) That depriving children of their rights to survival and development is not only violative of the International Convention on the Rights of the Child, but also of successive directives of the Supreme Court to enhance their right to education. The NHRC was requested to direct states to comply with these directives and not use population policies to deny these rights.

(*b*) That the 73rd and 74th Constitutional Amendments sought to strengthen and expand the base for India's democratic governance by providing constitutional recognition to local self-government bodies. The states' legislation on Panchayati Raj providing disqualification on the basis of the two-child norm, invariably cite the National Population Policy as the rationale for such a restrictive and punitive measure for elected representatives of the panchayats, when the National Population Policy does not provide such a norm. Moreover, similar disqualifications are absent for representatives elected to State Assemblies and Parliament. The NHRC was requested to take cognisance of this violation of constitutional rights, and direct states to strike down these provisions.

(*c*) That the NHRC take necessary measures to ensure that steps proposed in the so-called 'Strategy Paper' and the Uttar Pradesh Population Control Bill that violate human rights are not now included in the population policy.

It is shamefully poignant that policymakers, so anxious to control numbers, need to be reminded that a significant demographic transition is underway in large parts of the country. And that areas where this transition has lagged behind need assistance towards strengthening their health services and augmenting their anti-poverty programmes and not measures that punish the poor. And finally, if the health and well-being of people is the goal, what population policy planners should be concerned about is the stagnation in the IMRs, the huge load of communicable diseases and hunger, and the collapse of the public health care system.

The NHRC on its part responded with notices issued to the state governments and followed this up with a colloquium in early 2003 inviting representatives of the state governments and central governments, human rights groups, and health and women's activists. A declaration was issued at the end of two days of deliberations which read (NHRC, 2003: 1–2):

(*a*) Recognise that the population policies ought to be a part of the overall sustainable development goals, which promote an enabling environment for attainment of human rights of all concerned. Therefore, a rights-based approach is imperative in

the framing of the population policies. Further, it is important that framing of such a policy and its implementation require a constant and effective dialogue among diverse stakeholders and forging of partnerships involving all levels of government and civil society.

(*b*) Appreciate the efforts of the Government of India in framing the National Population Policy, 2000 of India which affirms the commitment of the government to its overriding objective of economic and social development, improving the quality of lives of people through education and economic empowerment, particularly of women, providing quality health care services, thus enhancing their well-being, and providing them with opportunities and choices to become productive assets in society, as a necessary concomitant to population stabilisation and reduction in fertility rates.

(*c*) Note with concern that population policies framed by some state governments reflect in certain respects a coercive approach through use of incentives and disincentives, which in some cases are violative of human rights. This is not consistent with the spirit of the National Population Policy. The violation of human rights affects, in particular, the marginalised and vulnerable sections of society, including women.

(*d*) Note further that the propagation of a two-child norm and coercion or manipulation of individual fertility decisions through the use of incentives and disincentives violate the principle of voluntary informed choice and the human rights of the people, particularly the rights of the child. Similarly, the use of contraceptive targets results in undue pressure being put by service providers on clients.

(*e*) Call upon the governments of states and union territories to exclude discriminatory and coercive measures from the population policies that have been framed, or are proposed. States in which such measures do not form part of the policy, but are nonetheless implemented, also need to exclude these discriminatory measures.

(*f*) Emphasise that in a situation where the status of women is low and son preference is prevalent, coercive measures further undermine the status of women and result in harmful practices such as female foeticide and infanticide.

Even as the NHRC was attempting to restore a semblance of sanity into the policy, there were attempts nonetheless to steer policy towards an increasingly authoritarian direction. The Government of India announced in April 2003 its plans to introduce in the Lok Sabha the Constitutional (79th Amendment) Bill seeking to restrict persons with more than two children from contesting elections (*Hindustan Times*, 2003). This Bill, introduced in the Rajya Sabha in 1992, would first have to pass the lower house. The health minister, speaking in the Lok Sabha, announced that should there be consensus on the Bill and that the government was prepared to introduce it in the ongoing session of Parliament.

But, not to be outdone, on the 31 July 2003, newspapers announced that a three-judge bench of the Supreme Court upheld the Haryana government law prohibiting a person from contesting or holding the post of *sarpanch* or *panch* if he or she had more than two children. The Bench observed that 'disqualification on the right to contest an election for having more than two children does not contravene any fundamental right, nor does it cross the limits of reasonability. Rather, it is a disqualification conceptually devised in the national interest' (Venkatesan, 2003: 1). But demographically unnecessary, this is not only a serious misreading of the relationship between population and resources, it is also an egregious assault on democratisation that is proceeding fitfully in our country. Indeed it is thoughtless folly that laws that specifically aim to empower Dalits, adivasis, OBCs, and other sections of the poor through PRIs are being circumvented by these imaginatively anti-democratic population policies. The judgement is also morally compromised since it violates the principle of natural justice, creating two sets of citizenship rights on the basis of fertility. Indeed such policies represent going back to the days before universal suffrage when property rights decided citizenship claims.

As has been noted by the former Secretary of the Department of Family Welfare 'in spite of the ICPD agenda and the adoption of the NPP, the population debate in India remains constrained by fears of a population explosion, highlighted by a small but vocal group of demographers and population experts. Unfortunately this fear of a population explosion/population scare continues to haunt not only demographers and population experts, but also the educated elite, the bureaucracy and political leaders' (Nanda, 2002).

This deep anxiety and fear about the growth of the population is thus reflected in a number of private members bills, which have been mooted to variously increase incentives or disincentives. Two of them, one named the Population Stabilisation Bill, 1999 (Lok Sabha Secretariat, 1999a), and the other, the Population Control Bill, 2000 (Lok Sabha Secretariat, 2000a), for instance, moot the ideas of a one-child norm along with a number of incentives and disincentives, including disqualification of persons with more than one child from contesting elections. Yet another bill, the Bachelor's Allowance Bill, 2000 (Lok Sabha Secretariat, 2000b), suggests incentives to those men who remain bachelors. Men who take advantage of the incentives and subsequently get married are to be fined and imprisoned. Yet another bill, the Population Control Bill, 2000 (Lok Sabha Secretariat, 2000c), also seeks to punish people who violate the small-family norm with rigorous imprisonment for a term of five years and a fine of not less than Rs 50,000. The Population Control and Family Welfare Bill, 1999, proposes in addition to incentives and disincentives, the compulsory sterilisation of every married couple having two or more living children (Lok Sabha Secretariat, 1999b).

While the debate on policy is in a mire of preventing a downslide into something more authoritarian, more draconian, more anti-democratic, at the field level, there has been no fundamental change of approach. Uttar Pradesh has reintroduced method-specific contraceptive targets of 10 lakh sterilisations and 30 lakh spacing method users per year by 2005 (Healthwatch, 2003). A study carried out by Healthwatch, Uttar Pradesh–Bihar, in 10 sterilisation camps in 10 districts of Uttar Pradesh in 2002, involving 253 female sterilisations, documents in detail the abysmally poor infrastructure, the lack of physical examination in several cases, and the inadequate sterilisation of equipment in a substantial number of cases. The average time taken for sterilisation was less than four minutes, with patients inadequately sedated and anesthetised. A substantial number of women had received no pre-operative counselling and a majority obtained no post-operative care. The study concluded:

> ... the bilateral assistance in terms of huge loans to avert population growth is being utilized as in Emergency days. Under RCH and CAN, the health services provided to the people of Uttar Pradesh are substandard .... The entire focus has been shifted from health and family welfare measure to sterilization targets, especially for women .... The

> government has shifted from its responsibility of providing primary health care ... [Through] the camp approach to meet these targets, people's health and welfare is being grossly neglected. (Healthwatch, Uttar Pradesh–Bihar, 2003)

In an earlier study, Healthwatch had documented 16 cases of sterilisation failures, two cases of sterilisation deaths, and one case of forced sterilisation within a two year period in Uttar Pradesh, after the adoption of a target-free RCH approach (Healthwatch, Uttar Pradesh–Bihar, 2002). Another report of a laparoscopic camp in Uttar Pradesh, noting the abysmal state of the facilities, the lack of elementary hygiene, the use of bicycle pumps for insufflation, the use of unsterilised syringes, indeed the lack of sterilisation of all equipment, concluded:

> The bottom line is the number of cases done in an hour, even though the national population policy now advocates a target-free approach. The numbers game played out in sterilisation camps across Uttar Pradesh under the Reproductive Child Health Care Programme has no rules. Human dignity and value for life are the biggest casualties in the programme that is aided by the Centre, the World Bank and some foreign agencies. (Saksena, 2002)

Yet another report, this time from a USAID-funded project area in Uttar Pradesh describing an astonishingly similar situation, down to the use of bicycle pumps for insufflation, noted:

> The camp has nothing to do with health, its only agenda is to offer sterilization. For this, each ANM attached to the PHC has been asked to get three cases per camp. Or lose their pay or even their jobs. As the doctor said, 'Call it SIFPSA or RCH or any other name, its all about some people making money out of health projects'. (Menon, 2004: 28)

An ethnographic study among lower-caste women in two communities, in Chennai and in a peri-urban community near Chennai, noted the routine introduction of IUDs immediately following deliveries and abortions in the public health facilities the women in these communities accessed, often without informing these women, and sometimes explicitly against their wishes. While it is true that such practices have declined, in 1997 when the scholar re-visited the study areas, this practice was still prevalent in large public hospitals in

Chennai where doctors felt they could not follow-up 'moving targets' in the community (Van Hollen, 2003: 232).

One thing that has happened in the 1990s is the huge growth of NGOs, aided both by Indian and foreign funds, that are currently involved in the implementation of the RCH programme. This is, of course, part of the policy prescription to countries under the SAP; it also represents a deeply held belief among sections of the policy élite that the public system is by definition bad and that if they cannot be privatised, they would function more efficiently when run by NGOs. Thus the NPP and state population policies all see a much larger space for NGOs and indeed the corporate sector (Qadeer, 2001). It is thus not accidental that the Andhra Pradesh state policy places an emphasis on 'marketing the population stabilisation programme' through contracted professional services, involving NGOs and the corporate sector.

Such policies are, of course, not original to India. It is not coincidental that USAID started precisely such a programme in Egypt called the Contraceptive Social Marketing Project, with an allocation of $12 million between 1988 and 1993 for the social marketing of contraceptives. Ali notes, for instance, that Egyptian NGOs have become the conduits facilitating internationally sponsored family planning programmes establish themselves outside the government control (Ali, 2004). The NGO dominance in the programme, in the case of Egypt, has meant that there has been in a shift away from development with equity to obtaining behaviour modification and providing a wider contraceptive 'choice' while NGOs themselves are crafted as voices of 'civil society', albeit an international one, given birth to by neo-liberalism.

Hartmann notes:

> In India, the government's recent capitulation to the IMF and consequent intensification of population control efforts are being accompanied by what activists call a 'buying-up' of NGOs by USAID. In the state of Uttar Pradesh alone, USAID is planning to spend 325 million dollars to reduce population growth in a scheme which includes the involvement of over a hundred NGOs. (Hartmann, 1993: 18)

This is, of course, not to deny that that some NGO's are doing excellent work in health and family planning, that some have served as models, that indeed a range of NGOs are involved on issues of

primary health care with no assistance from either the state or foreign donors. It is nevertheless important to discuss the analytical issues raised by the romanticisation of all NGOs and their increasing utilisation, often at public cost, to implement schemes. What is extremely important to realise is that NGOs are a broad and heterogenous category in terms of ideology, activities, funding, outreach, and effectiveness, and that any generalisation about them would be extremely weak, if not foolish. They are not necessarily, therefore, either more effective or efficient than any public-funded institution and cannot be used as a substitute for a variety of reasons. First, NGO activities are discretionary and not mandatory. Thus they can be socially exclusive, and indeed the fear that NGO-isation may be against the interests of Dalits has been frequently voiced by Dalit activists and scholars (Thorat, 2001). Second, they are not necessarily accountable, certainly not to the people they work with. Thus, while a politician has the admittedly infrequent chance of being voted out for incompetence or corruption by his constituents, NGOs cannot. Third, the whole issue of monitoring and regulation of the private and NGO sectors is an urgent and vexed question, but we have only to remember that the quinacrine sterilisations in the country were largely carried out by NGOs (Rao, 2001b). Indeed the myth that NGOs are somehow more 'representative' than political bodies has been so assiduously created in the age of neo-liberalism that this fundamental point has often been ignored. Thus the whole 'space' for 'Civil Society Organisations' in policy making bodies that rigorously include NGOs but exclude other civil society organisations like trade unions is problematic, if not suspicious. Finally, it is also not true that NGOs are internally more democratic: we have only to remember that the Rashtriya Swayamsevak Sangh (RSS) and the Vishwa Hindu Parishad (VHP), the largest network of foreign-funded civil society organisations in the country are deeply hierarchical, non-representative, anti-democratic, and indeed fascistic. Their concern for population is both neo-Malthusian and fundamentally and viscerally stems from a frightening and irrational hatred of Muslims.[6]

It is to be borne in mind that typically NGOs are small and often scattered; they are neither universally available nor accessible. Baru has shown on the basis of available data that NGOs providing health services are typically located in the better-off states and in better-off areas among them (Baru, 1999). Similarly, Visaria has noted that in

both Rajasthan and Madhya Pradesh, NGOs involved in health and development activities are located in only a few developed districts (Visaria, 2002a). The same point has also been noted for the state of Maharashtra (Duggal et al., 1986).

While the public health system has indeed to be critiqued and improved, questions have also to be raised about the economics and efficiency of subsidising NGOs. Baru has argued that there is very little empirical data to substantiate the assertion that the NGO sector is more efficient (Baru, 1999). The close association with state policies also leads to the weeding out or exclusion of NGOs that are opposed to some elements of state policy. Increasingly then only those coopted will find space in policy discourse.

In an obvious, but provocative simplification, Bose has observed that NGOs are basically DONGOs, donor-driven NGOs, or GONGOs, government-driven NGOs. The former, he observes, will collapse once foreign funding is withdrawn and the latter are often 'captured' by bureaucrats, ministers, or their wives (Bose, 2000). It is thus not surprising that over the 1990s, many NGOs have shifted from working on issues of primary health care to RCH (Baru, 2001). This should not be surprising for, as the UNDP notes, 'the share of resources accruing to NGOs has steadily increased, even though official aid transfers have been steadily declining. NGO revenues in the US total 556 million US dollars, in Japan 264 million US dollars and in the UK 78 million US dollars. In the developing world NGO budgets are nearly 1.2 billion' (UNDP, 1999: 95). The moot question, therefore, is whether the NGO sector represents one more case of public–private partnership? Of the public subsidising the private? Of the poor, once again, subsidising the relatively well off?

What we have, therefore, is the growth of private and non-governmental sectors in health care delivery, while the public health system become increasingly dysfunctional over the 1990s. At the same time, undermining the health of the population at large have been the effects of the policies of liberalisation, privatisation, and globalisation. The deflationary policies implemented have been eminently successful: they have increased the rate of growth of the economy, widened inter-regional and inter-class disparities, contributed to a consumption boom in the well-off classes even as they have squeezed the large mass of the population.

Perhaps most important have been the policy changes that have impinged on food security for households. Even as the country sits

on a mountain of unsold foodstocks of the range of 63 million tonnes, the per capita availability of food-grains has come down drastically from 177 kg in 1991–92 to 152 kg in 2000–2001; cereals have declined from 162.8 kg in 1991–92 to 142.8 kg in 2000–2001 and pulses from 14.2 kg in 1991–92 to 9.6 kg in 2000–2001. There has also been a decline in the off-take from the PDS, partly as a consequence of targeting, and partly as a consequence of declines in incomes. Per capita calorie consumption has also declined. Given increasing inequalities, this could only imply an increase in households unable to meet their basic food requirements (Patnaik, 2002). The reform policies have favoured income growth for particular top segments of the population and immiserised other, poorer, segments. As Patnaik notes:

> While at the higher levels of income (say the top decile of the population ranked by income) which has seen rising per capita disposable incomes over the last decade, there is indeed a voluntary diversification of diets towards higher value foods accompanied by rising nutritional levels, for those with below average incomes (roughly, the lowest six deciles) 'diversification' is the result of a cut in access to basic food-grains owing to a combination of falling purchasing power and denial of BPL ration cards, and hence this diversification is accompanied by falling per head calorie levels and deepening hunger. The average picture of overall decline is the outcome of diametrically opposite trends for these different segments of the consuming population—a rise for the minority and a large fall for the majority. (Patnaik, 2002: 5)

As we noted earlier, the period of reforms have also been marked by other features of distress in the agricultural economy, as a consequence of reduced public expenditure in rural infrastructure, and the removal of import restrictions. Thus a large number of states have witnessed suicides by farmers even as reports of starvation deaths have started coming in. What is even more striking is that given the lack of diversification and employment in the rural non-agricultural sector, women are being increasingly pushed back into agriculture. It need hardly be added that together these contribute to increasing vulnerability to ill health and disease in the population at large.

Accompanying global inequalities have been a huge upsurge in violence over the last three decades, increasingly taking sectarian colours. India too has been witness to this with growing Hindu fundamentalism, increasing violence against Dalits and women. Indeed

Human Rights Watch has concluded that here has been a sharp increase in violence against Dalits in general and Dalit women in particular (Human Rights Watch, 1999). We do not, of course, have systematic epidemiological data, but it is undoubtedly true that violence against weaker sections and the minorities have increased sharply during the reform period.

Equally significant have been other changes. Inter-regional, rural-urban, gender and economic class differentials in access to health care in India were well documented. But since the onset of liberalisation policies, these have considerably widened. The decline in public investments was matched with growing subsidies to the private sector in health care in a variety of ways (Baru, 1998). State support for private health care grew with the initiation of private–public partnerships that took a variety of forms. At the same time, there were far reaching changes in drug policies. Thus, India—earlier characterised by relatively low costs of drugs and pharmaceuticals, along with a significant indigenous production of drugs—has witnessed a greater concentration of drug production, a larger role for multinationals, a higher proportion of imported drugs and unbelievably steep rises in the costs of drugs (Sengupta, 1996). Concurrently, marked shifts have occurred in health care utilisation. Among people who sought out-patient services in 1995–96, more than 80 per cent did so in the private sector, a sharp increase in even the poorer states of the country (Sen et al., 2002). In 1995–96, 55 per cent and 57 per cent in the rural and urban areas respectively, were hospitalised in the private sector compared to 40 per cent in 1986–87. National Sample Survey data indicates greater inequality in use of health facilities by economic class gradients. In rural areas, the class gradient in in-patient use of public hospitals, which was insignificant in the mid-1980s, turned statistically significant in the mid-1990. In urban areas, inequality in use of public facilities did not worsen significantly, but inequality in use of private facilities did. The steep fall in rural hospitalisation rates, along with increasing use by the better-off indicates that the poor are being squeezed out. Fee-for-services is undoubtedly one important mechanism that has succeeded in doing this. In other words, World Bank policies on health, contained in the *World Development Report, 1993* succeeded in doing exactly the opposite of what was ostensibly its *raison d'être*—reduce the utilisation of public services by the better-off to increase access to the poor.

Costs of both out-patient and in-patient care increased sharply in both rural and urban areas, compared to the mid-1980s. Private out-patient costs increased by 142 per cent as against 77 per cent in the public sector in the rural areas. In urban areas, private out-patient costs increased by 150 per cent compared to 124 per cent in the public sector. The increase in costs for in-patient care is even more striking: average costs rose by 436 per cent in rural areas and by 320 per cent in urban areas (Sen et al., 2002).

The conclusion is inescapable: we cannot have so-called gender-friendly and poor-friendly population policies and health policies in the face of macroeconomic changes that are eroding the lives and livelihoods of the poor. Increasing unemployment and under-employment, decline in food security, further declines of whatever little measures of welfare that existed have meant increasing insecurity and indeed distress in the lives of the vast majority of the people. The failure to initiate structural changes is also one reason for the stagnation in birth rates.

NOTES

1. This was again a familiar, although completely absurd, argument. What it forgets is that 'medicines' are given to the sick, while contraceptives are given not to the ill or diseased but to healthy individuals. They are thus simply not comparable. Thus it is not legitimate to simply use the same tired arithmetic of woe in calculating costs and benefits.
2. Bose wrote: 'The main reason for the success of the Indonesian model is the excellent military logistics in running the programme. In India we have an overdose of democracy.' Bose, Asish (1994), 'Tamil Nadu's Successful Demographic Transition', *Financial Express*, 4 January 1994.
3. We live in a world of no certitudes except the illusion of choice offered by the market. Is this the reason for the unthinking popularity of such phrases? How else does one explain the fact that Madhu Kishwar argued that it is necessary to involve so-called religious leaders in a campaign against sex selective abortion since it is cost-effective (*The Times of India*, 1 July 2001)? Sadhvi Rithambra, best known for her role in anti-minority pogroms was part of this alliance. I have argued elsewhere against the wholy anti-female alliance this issue has brought together (see *Issues in Medical Ethics*, 9, 4 October 2001).
4. This, of course, calls into question the almost automatic relationship between female education, autonomy, and empowerment that has too many utilitarian takers to be enumerated.

5. Kumar, Devinder (2002), 'The Baby and the Bathwater', *The Outlook*, 29 April 2002, New Delhi. Similar reports were published in newspapers also, for instance an editorial in the Hindi newspaper *Hindustan*, 23 April 2002 entitled 'Again: We Two, Our Two'.
6. M.S. Golwalkar, the ideological fountainhead of the RSS wrote: 'To keep up the purity of the Race and its culture, Germany shocked the world by her purging the country of the Semitic Races, the Jews. Race pride at its highest has been manifested here. Germany has also shown how well-nigh impossible it is for races and cultures, having differences going to the root, to be assimilated into one united whole, a good lesson for us in Hindustan to learn and profit by' (Golwalkar, 1939: 35).

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6

CONCLUSION: THE MANY AVATARS OF MALTHUS

When Malthus published his first edition, the population of England was approaching 10 million and life expectancy was in the early 1930s. Malthus can perhaps be forgiven for not being aware of the enormous agricultural and industrial revolutions that were to transform not just England but the entire world. Indeed, he was himself to benefit remarkably from this phase of globalisation: he was appointed the first professor of the Chair of Political Economy established by the East India Company in the University of London. But much water has flown under Malthusian bridges and today Malthusian ignorance seems unforgivable. Yet, not only does neo-Malthusian thinking dominate in public health, it continues to provide 'explanations' for a host of social failures. How then, does one explain this continuing appeal?

Amartya Sen, discussing the relationship between health and development recounts a famous story from the *Upanishads* (Sen, 1999). This text from the eighth century BC recounts a conversation between Maitreyee and her husband Yagnavalkya regarding immortality and the means to achieve it, that is to say the relationship between wealth and health. Maitreyee wonders if she would be immortal if all the wealth in the world belonged to her. No, replies her husband, there is no hope of immortality in wealth. But Yagnavalkya could have added, if all the world's wealth belonged to you, the rest of the population of the world would have been 'surplus', or, irrespective of the actual population of the world, the world would be 'over-populated'.

Despite what is so frequently asserted as self-evident, common sense, and, therefore, somehow true, there is no clearly understood link between population growth and economic development or indeed between population growth and the environment. Although the world of demographers and population scientists is dominated by

those with a neo-Malthusian understanding of the question, there are nevertheless real and deep divisions. Desai notes that by and large 'demographers in the 1950s and 1960s almost universally accepted the contention that a high rate of population growth strongly inhibits economic development, and adversely affects the environment. By the early 1980s, social scientists had begun to exhibit considerable skepticism regarding this uncritical linkage' (Desai, 1998: 47).

Indeed a 1986 review sponsored by the US National Academy of Sciences issued a cautiously worded statement, to the dismay of the community of demographers. Explaining this statement, Kelley and McGreevey note:

> This statement ... exemplifies several attributes of modern economic thought on population: population growth has both positive and negative impacts; the actual net impact cannot be determined based on existing evidence; only the direction of impact from high current growth rates can be discerned; the net impact varies from country to country. (Kelley and McGreevey [1994], cited in Desai, 1998: 47)

It is thus not surprising that Tilly on the basis of a historical review of demographic structures and changes concluded: 'Over the long run, population growth and economic expansion generally accompany each other. Likewise economic decline and demographic contraction tend to occur together' (Tilly, 1978: 24). Indeed the classic by Habakkuk on population growth in eighteenth-century England outlines five ways in which substantial population increase stimulated economic growth (Habakkuk, 1971). These profoundly un-Malthusian reasons include producing economies of scale, promoting investment, making labour available, inducing technical change, and increasing agricultural productivity.

It is time perhaps to recall that it had been demonstrated with abundant data measuring the rate of growth of real national product per capita, or per man year or per man hour of labour input, that industrial countries showed no discernible correlation, negative or positive, with rates of population growth (Kuznets, 1956). It is time also to recall that population growth not only reduces requirements of capital per unit of product, but increases its supply. To recall too, Kuznet's conclusion—on the basis of historical evidence—that, other things being equal, population growth also has a positive effect on savings. All these economic lessons were lost to us in Cold War

politics that brought to the fore a completely different, and alarming, understanding of the issue.

Colin Clark's masterful historical survey concluded that the economic effects of population growth could be adverse in agricultural societies maintaining rigidly unchanging techniques of production and systems of land use. But, echoing Boserup, precisely in such groups, population growth results in the beneficial effect of inducing the adoption of newer and more productive systems and techniques. In industrial societies, on the other hand, population growth, in general, is economically beneficial. These conclusions are based on both national and regional statistics. Indeed, examining regional statistics on the growth of population and industry, the favourable economic effects of population density and population growth are 'confirmed to an embarrassing degree' (Clark, 1968: 279).

The beneficial economic changes provoked by population growth are only one part of much wider changes in the nature of societies. Rich empirical examples abound of the beneficial effects of population growth even in communities with a limited area of agricultural land. From ancient Greece in about the sixth century BC to Holland in the sixteenth century, Britain in the eighteenth century, and Japan at the beginnings of the late nineteenth, all furnish bountiful evidence of advances in population accompanied by great advances in a number of fields besides the economic. Greece during the sixth century BC gave us science, art, architecture, and philosophy. The Dutch in the seventeenth century, besides commercial and naval prowess, produced the greatest paintings in the world. Victorian England's contribution to literature and the sciences can also not be forgotten. India has perhaps also embarked on a similar trajectory.

One striking empirical truth that is undeniable is that improvements in human longevity have been associated with increases in human populations. A graph of the growth of populations superimposed on that of human longevity reveals their astonishingly close association. Most hunting and gathering societies, with low population densities, had an average expectation of life at birth in the region of 20 years or less; the global population is estimated to have been 6 million. The first big jump in life expectations, and in population, occured, of course, with the discovery of settled agriculture (Daimond, 1999). Global population increased to about 252 million. Average life expectations above the mid-1940s are relatively recent in human history and go back to the eighteenth century, when the

world population is estimated to have been 2,520 million (Wuyts, 1998). Average life expectations in the 1960s and above is more recent still, a twentieth-century phenomenon, with historically unprecedented population growth.

But this is also a field where a rational and historical examination of facts is often clouded, or occluded. We see then a continuing, if largely misplaced, faith in a neo-Malthusian understanding of the population issue. Truly protean, it can take myriad forms: that poverty in our country primarily persists due to population growth; that the poor do not know what is good for them and for society as a whole, behave irrationally, and thus need to be educated; that population growth among religious communities is because some religious groups seek to outbreed and take over 'our' country; the belief that affirmative action for the Dalits presents a threat to social well-being and indeed that all welfare schemes represent a waste of productive investments; that 'we' as a nation are in a bind, and having tried everything, the only way out is that the poor can and indeed must be coerced to control their numbers; that population growth represents the main threat to the environment; that population growth in Third World countries can act as a security threat to the interests of the powerful nations in the world and so on. Many of these beliefs are sanitised in public pronouncements, are made acceptable, and yet it is undeniable that they represent powerful undercurrents of thinking in an astonishingly wide range of areas.

What then explains this abiding belief in neo-Malthusianism? This question, though extremely moot, is difficult to answer with any certainty, since it involves feelings, opinions, and prejudices that are not always explicable. There are many and complex reasons, some inter-linked. One very obvious fact, of course, is that people have, for hundreds of years, believed in something simply because it is 'common sense'. The belief that the earth was flat and that it was at the centre of the universe, is one such belief, that still apparently has followers. This, of course, begs the question as to what is common sense and how this is created, or indeed constructed. Neo-Malthusianism offers a simple ordering of a complex, fractured, and frightening world. In this ordering of the world, God is indeed in His heaven and all would be well had it not been for the predilection of the poor to quite breed so incontinently. It is a profound alchemy of the mind that endows society with biological characteristics, all the better to control and recreate it. It allows us to think of the world without the

dangerous ideas of re-ordering a deeply unjust social order, indeed blaming victims, the 'them', who would otherwise threaten 'us' with their demands for equality and justice. It is not only a beguilingly simple explanation of the world, this explanation has also the imprimatur of the state and all powerful organs of dissemination of knowledge and information, constantly reiterated and restated in any number of ways. Indeed it might perhaps not be exaggeration to state that more resources have been spent on creating this common sense over more than a hundred years than any other such idea in the world. These ideas have always a strange way of resurfacing in what are perceived by some as incomprehensibly apocalyptic times when the world as we know it stands threatened, or is changing too fast for our liking, when we yearn for a prelapsarian age of innocence and glory, when things were said to be so much simpler. Thus the re-invention of tradition, the hatred of the heartless immorality of the modern, indeed of the demands of the hitherto dispossessed, which is also fundamentally part of this modernity.

Yet another factor is the ease, or the appeal, of a slinear, closed system thinking. It is thus not surprising that so many biologists, equating human societies with mango-flies or other instinctive creatures, frequently offer doomsday scenarios of population growth, as if humans are not reflexive, learning, reacting, eternally changing. Thus, when the doomsday predicted by one set of scientists is proven wrong, yet another group creates yet another scenario, remarkably similar to the first in its assumptions. So today we know that food production has more than kept pace with population growth, which indeed is coming down much faster than predicted all over the world. Initially scientists associated with the genetically modified (GM) industry argued that GM foods were necessary to increase food production to meet growing populations. When it became clear that this argument ran aground on the shore of empirical data, it was argued that they are necessary to keep pace with future rates of growth.

Nothing perhaps is more appealing to crude 'common sense' than the many images of human kind such thinking creates: the image of human societies as crawling over-breeding insects in a finite jar is one such. But the imageries are not always crude, appealing to the most insentient in us. Most such images of the population question undoubtedly appeal to the altruistic: the images of starving children, hungry mothers, eyes powerfully accusing, along with the message of over-population. Indeed

we are then exhorted to do something about it by contributing to population control in Third World countries. What many of these images also appeal to is the immediate, the un-reflexive, thus, the ahistorical, in a world profoundly troubled by history and impatient with it.

What is also extremely curious, and indeed frightening, is the atavistic appeals to blood, to tribe, and to race. Current post-modern distrust of the modern state and invocation of nativism unfortunately feeds its poison into this. For it is always a question of the 'other' who threatens 'our' order of things. The enormously furious impetus neo-Malthusianism offers to racism and, currently, to anti-immigration feelings primarily in the West is too well-known to bear repetition. But in a world where historic revisionism is current, where new tribal wars, described in a frighteningly aseptic pharse as 'ethnic cleansing', are unleashed every day, it is eminently desirable to retrace the links between neo-Malthusianism, eugenics, and the holocaust. It is an irony of history that victims of the holocaust, in the first modern country created on the basis of religion, in order to supposedly protect their 'race' are perpetrating yet another one today. By engendering fear and anxiety about the future, what neo-Malthusianism does is evoke complicity in morally offensive policies among people.

The collapse of multinational states as in Yugoslavia, the yearning for ethnically pure 'nations of blood and ties' that caused and were a consequence of this collapse, have something tragic to teach us. The horrible implications for huge sections of the population, ethnically cleansed into post-colonial states that have forgotten their anti-imperialist histories, is too recent to be forgotten. As Malouf has observed, the rush for identities, to seek some fundamental allegiance, often religious, racial, or ethnic, leads to murderous identities of blood. Responding to imagined atavistic fears and anxieties, we seem to be heading towards what Malouf describes as the age of 'global tribes' (Malouf, 2001).

Imbricated in this is the celebration of the pure 'community' even as ideas of the nation are scoffed at, when development is supposed to be automatically and necessarily linked to violence. This is accompanied by a deep distrust of ideas of rationality, curiously described as Western. Embedded in this discourse are spurious ideas of oneness with nature in the pre-modern past, of equally innocent ideas of the wholeness in human affairs in those golden ages, a forgetting that a tribal past was a past of constant and continuous warfare. In short,

that a tribal past, an ethnic past, a past celebrating blood ties, was equally oppressive to a large majority of women and men, the ants of these societies, put to labour and set to breed. My fear is that revocations of this past, suitably re-worked, would also mean a divestment of citizenship rights that tribal communities, of course, did not know about, or have use for. For as opposed to the membership of a tribe, what is at stake is citizenship of a nation.

Lionel Penrose, a British physician who questioned the central tenet of eugenic thinking, the heritability of mental disorders and intelligence, was puzzled by the frequent assertion among the élites that feebleminded people had strong sexual drives. There was simply no empirical evidence for these claims and yet there were frequent calls for eugenic sterilisation—although, of course, sterilisation is known not to decrease the libido. Penrose offered a Freudian explanation that is appealing. He wrote:

> It is a well-known psychological mechanism that hatred, which is repressed under normal circumstances, may become manifest in the presence of an object which is already discredited in some way. An excuse for viewing mentally defective individuals with abhorrence is the idea that those at large enjoy themselves sexually in ways which are forbidden or difficult to accomplish in the higher strata of society. The association between the idea of the supposed fecundity of the feebleminded and the need for their sterilization is apparently rational, but it may be emphasized by an unconscious desire to forbid these supposed sexual excesses. It is of course well known that advocates of sterilization never desire it applied to their own class, but always to someone else. (Penrose, cited in Kevles, 1995: 108)

Could this equally be an explanation for neo-Malthusian ideas about the reproductive profligacy of the poor? Could this be the explanation for the irrational communal anxieties about the Muslim rate of population growth? The frequent slogan '*Hum do, hamare do; Woh paanch, unke pachees*', which won the leader of the genocide in Gujarat in 2002 such a shameful but resounding electoral victory? Does this also tie in with the trope of the alleged vegetarianism of Hindus along with the sexual rapacity of non-vegetarian Muslims? Sarkar notes that 'there is a dark sexual obsession about the allegedly ultra-virile Muslim male bodies and over-fertile Muslim female ones' (Sarkar, 2002: 2874). Recounting the unspeakable horrors perpetrated on Muslim women and children in the Gujarat genocide,

Sarkar offers the following explanations. In communal violence, rape is a sign of the collective dishonouring of a community; the same patriarchy that views the female body as the symbol of lineage, of community, of nation—and their purity—would besmirch an entire community as impure and polluted once 'their' women are raped. There were also the calculated, and politically charged rumours spread of Muslim men luring away Hindu girls, 'a kind of penis envy and anxiety about emasculation that can only be overcome by violence'. And finally, the anxieties whipped up over generations about Muslim fertility rates, of their uncontrolled breeding and the dying of the Hindu nation, led to the brutal killing of children, the new blood of the Muslim race.

As early as 1909, U.N. Mukherji had written a book entitled *Hindus: A Dying Race*, which went on to influence many tracts and publications of the Hindu Mahasabha, the parent organisation of the RSS.[1] This book seemed to meet a widespread demand, going in to many reprints, feeding into Hindu communalism. It had a special appeal to Hindu communalists at this time, anxious to create a monolithic Hindu community, in the face of demands for separate representation emanating from both Muslims and lower-castes. Whipping up anxiety about Muslims would be one way to weld together hugely diverse, and often antagonistic, castes into one community, erasing the structural divisions in caste society. Indeed it has been noted that 'for Hindu communalism, it [the book, *A Dying Race*] had a more direct resonance as Hindu communalism was now preoccupied with numbers ... the possibility of low castes declassifying themselves as Hindus was a motivating anxiety behind the origins of Hindu communalism' (Datta, 1999: 18). Deeply riddled with inaccuracies, making predictions about the future on absolutely no rational basis, the book nevertheless provided 'demographic common sense functioning as a trope for extinction' (ibid.: 23).

Emblematic here was the tragic figure of the Hindu widow. Forbidden remarriage among the upper castes—now increasingly emulated by sanskitising lower castes—she was at once responsible for the dying of the 'Hindu race' as she was an allurement for virile Muslim men, a danger within the sacred heart of the Hindu household, waiting to be profaned. Fitting neatly into this gendered anxiety was the communalisation of the issue of 'abduction' of Hindu women. Indeed this too was prominent in the form of epidemics of rumours before the Gujarat genocide two years ago.

In an extraordinary work Anandhi shows how neo-Malthusian concerns were transformed into upper-caste anxieties about the lower castes in Tamil Nadu (Anandhi, 1998). She notes the ease with which the upper class neo-Malthusian agenda interweaves with the upper-caste agenda of Brahminical Hinduism to reduce women to merely reproductive bodies requiring male control in a reimbrication of patriarchy. A number of men, predominantly Brahmin, involved in the early debates on birth control, members of the Neo-Malthusian League in Madras in the early twentieth century, invoked Brahminical texts that apparently regulated the sexuality and thus the birth rate among Hindus. Thus is achieved the seamless welding of 'Hindu' with upper-castes, the conflation of upper caste practices and norms as Hindu ones. Thus Krishnamurthy Ayyar, noted that in the case of Hindus, the code of Manu imposed certain marriage practices that were anti-natal, although curiously he does not mention the deeply embarrassing topic of debate, the situation of widows in upper-caste Hindu society. This apparently prevented over-population of Hindus, while conversely creating over-population of those communities not similarly guided by the code of Manu. He also added that upper-caste dietary code of vegetarianism was perfect for regulating reproduction by dampening sexual appetites:

> Taking the people of India, the birth rate among the Brahmins, particularly those of Madras and other purely vegetarian communities is the lowest except among the Parsees.[2] The Mohammedans who partake of animal foods have increased from 1881 to 1921 ... the Brahmins, who are purely vegetarian, there was no increase between 1891 and 1921, but a fall. (Ayyar, cited in Anandhi, 1998: 143)

What was central to the arguments here was the reproductive excesses of the lower castes, their unbridled sexuality, the need, therefore, for upper caste normative control—defined in terms of desexualising lower caste bodies. As Chakravarti has argued, what Brahminical patriarchy feared, indeed what was supposed to have brought on Kaliyuga, was miscegenation, 'the purity of women has a centrality in brahminical patriarchy, because the purity of caste is contingent upon it' (Chakravarti, 1993: 579). In short, the lower castes had to practice birth control both to improve the Hindu race and to emulate the upper castes who supposedly practiced continence except for reproductive purposes.[3]

As Ayyar observed:

> As long as the germ cells belong to the race and human beings are their trusted custodians, birth control should not be resorted to unless it is for considerations of health or economic conditions. If it is practiced with the view to shirk responsibility and to lead a life of merely carnal pleasure, it is committing a crime towards the race. (Ayyar, cited in Anandhi, 1998: 144)

What is curious, and indeed striking, is that although there is anxiety about the sexuality of the lower castes, Hindutva does not seem to reveal obvious anxieties about the numbers of the lower castes. On the one hand, as the experience of Gujarat indicates, this could be related to the fact that Hindutva anxieties are largely focused on the growth rates of Christians and Muslims and that they see the Dalits and the lower castes as foot soldiers in their fratricidal war. On the other, this could be related to their obvious role as perhaps the sole producers of value. The statement of a landlord in Tamil Nadu to Human Rights Watch illustrates this:

> In the past, dalits enjoyed the practice of untouchability ... the women enjoyed being oppressed by men. Ladies would boast that my husband has more wives. Most dalit women enjoy relations with men. They enjoy upper caste community men having them as concubines. Anything with dalits is not done by force .... Without dalits we cannot live. We are landholders. We want workers for the fields. Without them we cannot cultivate or take care of our cattle. But dalit women's relations with other men are not out of economic dependency. She wants it from him. He permits it. (Human Rights Watch, 1999: 31)

The novelist Julian Barnes, baffled by the appeal of Thatcher, notes that her achievements were truly remarkable. She revealed that it was possible at times to do the truly unthinkable. Mrs Thatcher taught us that: 'You could survive while allowing unemployment to rise to levels previously thought politically untenable. You could politicize hitherto unpolitical public bodies, and force the holy principles of the market into areas of society presumed sacrosanct. You could sharply diminish union power and increase employer power .... You could make the rich richer and the poor poorer until you had restored the gap that existed at the end of the last century .... You could do all this and in the process traumatize the opposition ... and even manage to

get votes from the unemployed' (Barnes, 1999: 546). How did she manage this? One, alas all too appealing way was, of course, by appeals to demagoguery and chauvinism. The second was what Barnes calls the 'gut appeal to nature'. But, of course, a nature modelled on capitalism, much as Darwin did with talk of the survival of the fittest. Thus natural is constructed to mean the celebration of supreme and uncurtailed self-interest of the rich, and competitiveness in society. If nature was indeed this way, who were we to intervene? Perhaps it is hubris to intervene? Nature, in other words, appears to tell the listener that the poor and other victims of the system are merely reaping what they sow, just as the rich and the privileged do. What Thatcher did, much as Malthus did before her, was to reduce complexities of social life to simple homilies, replacing hesitation and questioning with granitic certitudes. In short, the success of neo-Malthusianism is the reduction of unpredictabilities, of uncertainties of social sciences with the hard givens of Malthusian arithmetic.

As has been repeatedly observed, there exists startling similarity between Malthusian times and neo-liberal ones. Indeed, the rebirth of socio-biology, the ideas of race and IQ that had been considered buried in the 1980s testifies to this. As Thatcher famously said, there is no such thing as a community, only an individual. What is perhaps equally important is that this project of desocialising and depoliticising individuals finds more than metaphorical resonance in public health. This has meant the dominance of methodological individualism, the belief that a community comprises merely a sum of individuals, and in terms of methodology in public health, a preoccupation with the parts as opposed to a whole, an undermining of the population basis of public health. This has reached its apogee in the geneticisation of health—a clear shift in the relative weight one places in public health between the individual and the environment—accompanied by the diminution in the salience of environmental factors. This is reflected, for instance, in the overwhelming importance attached to individual, so-called lifestyle factors in explaining contemporary patterns of disease and death, to the exclusion of more socially constructed explanations. Indeed the word public itself is to be dismissed, cast off into the dustbins of history, resonating as it does with socialism or the welfare state or the Evil Empire. What we are instead to celebrate is a community of consumers. Indeed, not surprisingly, people today are referred to in policy documents as stakeholders, more than metaphorically resonating with shareholders.

But this individualist approach in public health is seriously flawed. Recent data on secular mortality trends indicate that social change can result in sizeable changes in disease risk within populations while interventions targeted at individuals have little impact (Davey Smith et al., 2000). Reviewing empirical data on mortality due to the cumulative experience of social disadvantage Davey Smith, Gunnel and Ben-Shlomo reveal that socio-economic circumstances at different stages of life contribute significantly to mortality in adulthood, albeit differing between different broad causes of death. This is not, of course, to argue that individual factors are unimportant, but to contextualise them, both to understand causation and to design policy at the population level. Thus 'the socially patterned processes which concentrate exposures ... increase the risk of these diseases in ... disadvantaged groups ... underlie inequalities in overall health status. The social structure leads to clustering—over time and cross-sectionally—of multiple factors' (ibid: 114). Thus, that diseases and deaths are socially patterned and have to be understood as such. An individualist reading, is therefore, only partially true and entirely misleading; it offers a partial description and no explanation. In other words, the mortality load in a population is not merely natural, but reflects the social, economic, and political arrangements of society, prior factors affecting the health of the population.

The fact that health inequalities have widened across the globe in the last two decades of neo-liberalism further substantiates this point. The Black Report in UK for instance showed a substantial increase in mortality differentials by class; the mortality rates among the unskilled working class men in 1981 were higher than they had been ever in the twentieth century, deteriorating after 1971 (Townsend and Davidson, 1992). Over this period, while diseases changed and technologies radically improved, while more was spent on medical care that was accessible to the entire population, what did not change were the social differentials in mortality. Indeed these inequalities in health widened sharply during the Thatcher years. Equally, class differences in heights among school children have again begun to widen. Substantial GDP growth, then, accompanied by greater inequality in wealth distribution, and social hopelessness, clearly had a regressive effect on health. But an individualist reading clearly blames individuals, the victims of the system and takes attention away from real causes.

It is this too that explains the resurgent domination of neo-Malthusian thinking across the world, taking many forms. It is abundantly clear that since the 1980s, inequalities across the globe and within countries have substantially increased. This has led to increasing levels of both absolute and relative poverty. As a result, advances in health made earlier in the twentieth century, accompanying de-colonisation of Third World countries, and with the building of welfare states in the West, are being undermined. Indeed, in many countries across the globe, there have been increases in levels of infant and child mortality even as life expectancy has declined. Under the regime of globalisation, liberalisation, and privatisation, while a small proportion of the world's population is becoming increasingly wealthier, unemployment, loss of assets, and deprivation are increasing in a widening share of the world's communities, including the poor in rich countries, and this is profoundly shaping health. Expectation of life at birth has declined sharply in countries of the former Soviet Union, in large parts of Africa, and in some parts of Latin America. In Russia, innocuous diseases like measles, which had disappeared, have not only made a reappearance but have commenced taking a toll, riding on the back of increasing hunger, unemployment, and the collapse of the welfare state. There has also been a resurgence of that disease of poverty and hopelessness, tuberculosis, albeit in a new and more lethal drug-resistant form. There is an imperative need to acknowledge that health improvement is less an outcome of medical technology than of living standards. Earlier efforts in India towards integrating health with overall development, albeit achieved in a limited manner, have been seriously undermined by new initiatives under the aegis of the World Bank to drastically reduce the role and vision of public health, to one based on technological hubris. At the same time, the role of the state in the provision of the determinants of health is radically undermined. Health improvements based on narrow technical interventions are bound to be chimerical, as indeed had been the experience of India's malaria eradication programme. Health, then, holds a mirror to human civilisation. What we see today is not very ennobling or dazzling.

I am not arguing that family-planning technology is not important, that people do not need it, that women in particular, do not seek it. On the contrary, my argument is that contraception is a right. It is a right as much as, and closely imbricated with, a right to health, a right

to development, a right to security of our lives and our children's lives, and indeed a right to hope for the future. In the health sector, the closest we have come to recognising this is with the Alma Ata Declaration of Health for All through Primary Health Care.

What I have also tried to demonstrate is the many forces, political and economic, would wish to impinge on these rights for all of humankind. This struggle for rights for all of humankind may well be described as laughably Utopian. But which Utopian in India would have imagined a hundred years back that the right of the Dalit to vote would be self-evidently a citizen's right in our country? As someone said, if we want to create angels, we might need to specify the heavens they will take abode in.

There has, of course, been a discernible shift internationally in sections of the international population establishment. There has been a realisation that a single-minded focus on birth rates, on demographic doom and catastrophe that this stemmed from, is neither desirable nor feasible; indeed it is unnecessary. It is this realisation, compelled in part by the failure of other earlier population control initiatives, which drives the current emphasis on reproductive health and rights. These are indeed steps forward that were fought for, that are now fraught and need to be defended. And there is indeed a move spearheaded by the neo-conservative George Bush, Junior to do with away with all the international covenants enunciating these rights.

But while these are necessary, they are also simply not enough, they feed into a replay of old tropes, of demographic concerns separated from larger concerns that they are intrinsically a part of. The focus on reproductive rights thus may well obscure, as it often does, these larger concerns.

Unfortunately, the euphoria generated by the feminist victory of reproductive rights has led to a weariness, a feeling that this is all very well, but what does it have to do with controlling population here and now. This is discernible in influential circles in India, impatient to get back to the bad old days when something was being done, instead of talking abstractions.

Sen drawing attention to the pessimism in Malthus, as opposed to reasoned optimism in Condorcet, points out that the differences in approach between these thinkers on the population question become even more apparent when we think of solutions. Condorcet would thus call for the absence of Malthusian fatalism, and the willingness to look for solutions to difficult social problems, rather than accepting the

inevitability of misery. This would also mean a rational search for the effectiveness of alternative social and economic policies. Above all, it would mean keeping faith in the voluntary, reasoned, decisions of people rather than any element of compulsion in decisions involving fertility (Sen, 1994).

NOTES

1. Curiously Sidney Web wrote his tract *The Decline of the Birth Rate* at about the same time. He was concerned the English were committing 'race suicide' with the population of England becoming increasingly Jewish and Irish (Jayal, 1987).
2. This sentence is riddled with minefields, defeating Ayyar's own argument, since he notes that non-vegetarian Parsees also had low birth rates. Nevertheless there is a curious, and entirely incorrect, characterisation of Brahmins as strictly vegetarian. Indeed the Brahmins of Kashmir, who consider themselves the Brahmins of Brahmins, are non-vegetarians, as also the Brahmins of Bengal and south Kanara. But today at the height of Hindutvavadi resurgence it is being asserted that all Hindus are essentially vegetarian in a move to deny beef to the Dalit and Muslim communities.
3. This indeed was Mahatma Gandhi's position on birth control.

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Mohan Rao is Associate Professor at the Centre of Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi, and has been a Visiting Fellow at Oxford University. A medical doctor by training specialising in public health, he has written extensively on the history and politics of health and family planning. Actively involved with the People's Health Movement, he played an important role along with the All India Democratic Women's Association (AIDWA), in the Supreme Court ban on quinacrine sterilisation of women. His recent books include *Disinvesting in Health: The World Bank's Prescriptions for Health* (edited) and *The Unheard Scream: Reproductive Health and Women's Lives in India.*

... a powerful history and critique of population control in India, [this book] raises the population policy debate to a new, higher level. With careful documentation and eloquent prose, Rao shows how the single-minded focus on reducing birth rates has wreaked havoc on India's public health system, violated basic human rights, and reinforced class and gender inequities.... Challenging neo-liberal prescriptions, Mohan Rao's path-breaking analysis puts primary health care back at the centre of population policy, where it rightfully belongs.

Betsy Hartmann
Author of Reproductive Rights and Wrongs

[This book] lives up to that forgotten but still great tradition of assisting present and future students to revive 'the banal but forgotten academic understanding that critiquing is useful, legitimate and indeed necessary'.... A must read for planners and practitioners in the field....

Vina Mazumdar
Centre for Women's Development Studies, New Delhi

The Indian family planning programme, one of the largest public health initiatives in the world, has adopted various strategies since its inception—none, however, have yielded the desired results. What are the reasons for this? Why do large sections of the elite blame the population 'explosion' for all the social and economic problems that India faces?

Answering these questions, the book critically evaluates the family planning programme in India, exposing its biases and skewed priorities. It argues that neo-Malthusian ideology has profoundly influenced not only demographers, but also policy planners, the medical profession, and, indeed, the middle class and the elite as a whole. Strongly critical of the impact of neo-liberal economic policies on the already ailing public health care system in India, Mohan Rao argues that the recent emphasis on health and reproductive rights adopted by the Indian government has done little to improve the health of women.

Overall, the book contextualises the debates concerning population and development in a broader socio-historical and political framework, highlighting new empirical findings and policy implications. Well-researched and refreshingly original, this book is singularly relevant today with ICPD marking its tenth anniversary. It will be of interest to scholars of public health, social demography, population studies, women's studies and policy studies. It will also be essential reading for students in the health professions, policymakers, health groups, women's groups, and journalists writing on these issues.

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